

## **Preparing Our Nation's Healthcare System for Ebola Transcript**

**Moderator: Ingrid Caples**

**October 31, 2014**

**2:00 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 one on you 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 Mr. Gregg Margolis. Thank you, sir, you may begin.

**Gregg Margolis:** Good afternoon and thank you for joining us to this teleconference on Preparing Our Nation's Healthcare System for Ebola. My name is Gregg Margolis and I'm the director of the Division of Health System Policy in the Office of the Assistant Secretary for Preparedness and Response in the United States Department of Health and Human Services. This is our third call for hospital executives, hospital emergency management directors, and safety officers and this is part of a comprehensive approach that we have been taking over the last couple of weeks to hold calls with as many stakeholder groups as possible to keep them regularly updated on new information as it becomes available related to the Ebola situation in the United States.

We continue to listen and field questions from our private sector state and local partners and we're very appreciative of you taking time to join us today. I would like to point out that the transcripts and recordings from all of the previous calls as well as today's call are - will be posted - are - the previous calls are currently posted and this one will be posted on phe.gov along with a variety of other resources that may help you prepare your healthcare system for Ebola. And I'll also point to the excellent resources that are available on the CDC Web site and obviously we will continue to update those resources as the situation evolves.

Today we have a group of experts from across the U.S. government that are working on various aspects of the Ebola response. We have representatives from the Office of the Assistant Secretary for Preparedness and Response, Centers for Disease Control, Center for Medicare and Medicaid Services, Intergovernmental and External Affairs, and the Department of Transportation.

Our outline for today is a brief overview of a number of topics and then we will leave plenty of time for questions and answers. We are going to cover a brief overview of a regionalized approach to identifying hospitals to treat EVD patients. We'll talk a little bit about issues related to personal protective equipment and some waste management considerations. At this point it is my pleasure to turn things over to Dr. Nicole Lurie, the Assistant Secretary for Preparedness and Response who will provide opening remarks and an update on the work that's being done at ASPR. Dr. Lurie.

Dr. Nicole Lurie: Thanks Gregg and hi everybody and Happy Halloween. So hopefully this is more of a treat than a trick, but thank you for joining us all this afternoon. I've gotten a lot out of each of our teleconferences and conversations and I will say

the questions that keep coming up and being asked are what help us to figure out how we can best meet your needs and really have pointed us in the direction of a number of training opportunities, guidance, developments, and other considerations. So I'm looking forward to today's discussion as well.

I think you've all heard time and time again that our primary concern has been with the Ebola epidemic in West Africa and that the most important way that we can keep ourselves safe in the United States is to end the epidemic in West Africa. Many, many of our U.S. government's efforts are pointed in that direction. But you also know with the events over the last couple of weeks with Mr. Duncan and the infection of the two nurses that take care of him and now Dr. Spencer's illness that we cannot for one moment let down our guard here at home. Even though -- in the face of those four cases -- we understand that an Ebola outbreak here in the United States is extremely unlikely.

It is likely, however, that we'll see another case or more cases of Ebola in the United States because of the current situation and our goal will be to be sure that we recognize them early and limit any secondary infections that might occur at the same time that we're able to safely take care of an infected individual. And so I think all of you know that there are a number of screening and other monitoring procedures in place to help us do just that.

I always say that good preparedness and response is built on the back of strong day to day systems. And in this case it takes both a strong public health system and a strong healthcare system to be sure that we can remain safe at home. And I think I'm talking to most of you on the phone are representatives of our very strong and able healthcare system. I think it's terrific that the survival rate from Ebola in this country has been as good as it is and I think it's an incredible testament -- again -- to the availability of high quality medical care.

I also think it's a huge tribute to advancements in patient quality of care and safety and infection control that we've continued in our efforts to limit the spread of infection, both in the community and among healthcare workers.

I want to focus on two major issues today - or maybe three. One is concerns among healthcare workers. Secondly I know a lot of you are hearing about some of our issues and plans around identifying hospitals that can take care of Ebola patients. And third, something that's related to both of those and that's the status of personal protective equipment.

So I think if you've been on any other prior calls with me you've noticed that there's been an ask to healthcare executives around the country to say, you know, "We believe that every hospital around the country needs to be prepared to recognize a case of Ebola, isolate a suspected person, use the highest available PPE that they have available at the time, put a patient in a room and isolate them, and call for help - call your state or local health department and call the CDC."

If there were a patient with Ebola, CDC would send a rapid response team -- a SWAT team -- there to help you until that patient could be safely transported to an Ebola treatment facility. So we've asked you to be able to detect a case, we've asked you to do a drill or exercise that looks at your ability to detect and safely isolate a case. We've asked you to conduct a medical and nursing grand rounds. And then for frontline workers for whom it is appropriate, we've asked you to be sure that people understand how to safely use PPE or personal protective equipment.

We have been moving forward very rapidly now with the identification of hospitals that are able to take care of patients with Ebola. I think all of you

know that we started this in concert with the funneling of all travelers from affected countries to five major airports in the U.S. And at this point there are identified facilities near each of those airports that are able to safely treat an Ebola patient in addition to Emory, Nebraska -- although Emory I guess is in Atlanta.

We are moving now to identify and bring into this circle of Ebola treatment facilities hospitals that are located in two areas. One, areas that are destination for lots and lots of travelers and -- two -- areas in which many people from the Diaspora live. It turns out that those are pretty overlapping areas, so that's not so surprising. And we have been identifying facilities in those regions with a goal that we'll have a good geographic representation or good enough that - geographic representation that no matter where somebody might show up in the U.S. with Ebola -- if that were to happen, and again we think it's highly unlikely for remote areas, but if that were to happen -- people would be within a long ambulance ride of an Ebola treatment facility.

And then the third group of hospitals that we're trying to identify is basically filling in the space after we get through the airports and the regional areas where Diaspora populations live. I'll tell you that we're making great progress on that. But for a hospital ultimately -- I think -- for us to consider them an Ebola treatment facility a couple things have to happen. One is they need to volunteer. We are not as a federal government forcing anybody to do this.

Secondly they need to have an assessment from a CDC - the rapid Ebola preparedness team -- the REP team -- who will consult with them about their level of readiness and look over their facility, their staffing, their policies and procedures. There are about 13 or so different dimensions that are assessed. In addition, the state health officer needs to agree that this is a facility that can and should be taking care of Ebola patients if one is referred to them. We are

also moving toward a system where there can be an externally validated peer reviewed system of readiness for Ebola hospitals. And I think you'll hear more about that in the days and weeks to come.

But I want to reiterate, nobody is being forced to do this. We've been very gratified with the volunteers that have come forward. And we know that many, many of you around the country -- even if you've just been thinking about stepping up -- have been practicing. Have been doing your drilling and exercising. Have been reviewing your hospital infection control policies and procedures, have been educating your staff and -- in many instances -- have even done some construction to be sure that you have -- for example -- an area that's safe for putting on and taking off personal protective equipment or that you can do labs approximate to a patient if that were necessary.

And we appreciate so many of the efforts here. We also know that those of you who will never be Ebola treatment facilities -- either because you don't want to or because you're not equipped to or because you're not in a region where that's necessary -- have also been doing a lot of training and drilling and exercising and that's exactly what you should be doing.

I want to just close with a couple comments about personal protective equipment. As you know, the CDC released guidance on personal protective equipment that was updated from its previous guidance and I think the combination of that and the cases in the United States have spurred both a lot of preparedness on the part of hospitals and frankly a lot of really panicked buying on the part of hospitals and EMS agencies and public safety agencies.

We know that that has resulted in shortages, particularly of some preferred equipment and spot shortages of others. One of the reasons that the CDC guidance offers choices is because there's not always a one size fits all

solution for people and also because you know that sometimes if you can't get exactly what you want that there's other PPE that will keep you just as safe and will be available.

But I will say that not every hospital in the country needs to maintain a massive stockpile of personal protective equipment. And next week -- I believe -- the CDC will be releasing some additional guidance to help you with how much and what kinds of PPE non-treatment hospitals -- i.e. those that are not going to long term take care of a patient with Ebola -- should have. So that you can make some sane and rational purchasing decisions.

In the meantime if you are feeling like you can't get personal protective equipment that you need, I would urge you first to go to your healthcare coalition because the coalitions are working with local hospitals and state and local health departments to get visibility on the supply and to try to rationalize it. I would then ask you to go to your state health department if you can't get PPE and ask them to help you get what it is that you need.

They will validate in fact that the need is as you think it is or maybe help you understand that you might not need as much as you think you do. And then if for whatever reason folks in the state can't get their hands on PPE -- which by and large so far exists -- they will ask the strategic national stockpile for help. So that is the procedure. And I hope that that helps you understand how to get your hands on it.

We have had a lot of calls over the past week from hospitals and health departments all over the country. Many have been concerned enough to call their elected officials or to get in touch with the Ebola Czar. I will tell you that in every instance so far we have been able to work with the hospital and the health department and their community to find personal protective equipment

within their community or to help people to understand that maybe Ebola stockpiling a hundred or a thousand of whatever kinds of pieces of equipment it is is probably not the best use of your money.

With that said, we do understand that there are a lot of people who feel the need for training and would like to have equipment to train in and are working hard on this. So that's all I really wanted to share with you today. I am going to turn this back to Gregg Margolis and I look forward to your questions.  
Thanks.

Gregg Margolis: Thank you Dr. Lurie. Now I would like to introduce our colleague from CBC Dr. Arjun Srinivasan. He is the Associate Director of Health Care Associated Infection Prevention Programs in the Division of Health Care Quality Promotion at the CDC to give us an update from the CDC.

Dr. Arjun Srinivasan: Hi this is Arjun. Thank you so much for allowing me to join the call. I wanted to hit a couple of highlights on recent guidance from CDC on personal protective equipment and infection control considerations for patients with Ebola. The first is one that was released a little bit more than a week ago now. It was a guidance for - a revised guidance for the care of patients who are hospitalized with known or confirmed Ebola virus disease. This was a change from past guidance that we had issued for patients hospitalized with Ebola virus and was based on what we have learned about caring for these patients in the experience of the centers that have dealt with this first hand in the United States, Emory, Nebraska, the NIH Clinical Center.

And what the guidance reflects is our increasing understanding of the complexity of the care that needs to be provided to these patients to deliver them the high quality care that looks like it is actually saving lives in this country. We recognize that this care is very complex and can change suddenly

and the guidance is mean to incorporate that lessoned learned into the guidance. There are three main principles that underscore the new guidance.

The first is that health care workers need to have a thorough training and assessment on the use of whatever personal protective equipment is to be used in your hospital. The second is that they not have any skin exposed when providing care for a patient with Ebola and the third is that the health care worker be observed at every step of putting on and taking off the personal protective equipment and those are three core fundamental principles.

Another change I would like to highlight and explain a little bit is the change away from a surgical mask towards some sort of respiratory protection. Either a disposable N95 type respirator or a powered air purifying air respirator or a paper. I want to - I do want to emphasize that the reason or this change is not because we think Ebola virus is airborne. Extensive clinical experience with Ebola outbreak in Africa demonstrate that Ebola is not transmitted via an airborne route. However, what we are learning from the care of patients in this country is that there are circumstances where an aerosol generating procedure, for example intubation, might have to be done somewhat urgently.

In that situation, we want our health care workers to be protected and not have to leave the room to put on the right type of respiratory protection. As many of you might know from your practice with putting on and taking off this equipment, it takes quite a bit of time to take off and then put on the protective equipment that is recommended so we want health care workers to be ready to do whatever they might have to do the moment they are entering the room - they enter the room.

That is the guidance for hospitalized patients with known Ebola virus disease. There is also new guidance for emergency departments where patients might

be coming to be evaluated for Ebola. These are patients who are not known to be infected, but have a travel history or an exposure and some sign or symptom that could be consistent with Ebola. It is important to not that this is an issue that many of you probably have already confronted in your hospitals. We know that there have been a very large number of these patients who have come to hospitals for evaluation, come to emergency departments, but we also know that very, very few of them have criteria that are suspicious enough even to order a test and of course we know that you know very, very few of them only one in fact had a positive test for Ebola.

So the vast majority of these patients who come to the emergency department in fact don't have Ebola, but guidance for the evaluation in emergency department revolves around three principles - identification, isolation, and informing public health. We recommend that patients be screened at entrance to emergency departments for these risk factors. The travel or exposure history and the symptoms. If they do have both have both of those criteria, we recommend that the patients immediately be isolated, be placed in a private room, and then staff entering the room and wear protective equipment based on the symptoms that a patient might have.

So a patient who doesn't have vomiting or diarrhea who might maybe only have fever or only maybe have has a headache for example. You can use gowns and gloves and a mask to enter that room but you don't have to use the full protective equipment that would be recommended for a hospitalized confirmed cases. However, if the person does have vomiting or diarrhea then we think that the risk of spores is higher. And even though we know the vast majority of those patients don't have Ebola, in fact almost all of them don't have Ebola, we still recommend that if you are entering the room in the ED to evaluate someone with vomiting and diarrhea. You should go ahead and wear

the personal protective equipment that is recommended for hospitalized patients.

And I think those are the highlights of the recent guidance that I would like to touch on and I of course will be on the call and happy to take any other questions that might arise. So I think I will turn it over back to you all.

Gregg Margolis: thank you Arjun. At this point I would like to turn things over to Christina Tackett from the United States Department of Transportation Pipeline and Hazard Materials Safety Administration.

Christina Tackett: Thank you for inviting me to the call today. I will start with an overview of the Department of Transportation DOT's role in the transportation of Ebola Contaminated Waste and then I will give some updates about what the agency has been doing with respect to this waste. The DOT's pipeline and hazard material safety administration also known as (FIMSA) is responsible for regulating and ensuring the safe and secure movement of hazardous material by all modes of transportation to minimize threats to life, property, or the environment due to hazardous materials related incidents.

The hazardous material regulations, the HMR, regulates the transportation and commerce of hazardous materials including Ebola, which is classified as a Category 8 infectious substance. When transporting materials, contaminated or suspected of being contaminated with Ebola. The HMR imposes certain labeling and packaging requirements that go above and beyond the requirements for transporting regulated medical waste. To transport materials contaminated or suspected of being contaminated with the Ebola virus, a special permit may be necessary to allow for a variance of the HMR packaging requirements to transport and handle the larger volume of contaminated waste generated during the treatment of Ebola patients.

In most cases, these special permits are issued to the carrier or a waste hauler. DOT may grant a special permit if they applicant can demonstrate that an alternative packaging will achieve a safety level that is at least equivalent to the safety level required under federal HAZMAT law or as consistent with the public interest if a required safety level does not exist.

Since they issue two special permits to (serocycle inc) a waster hauler to handle the waste generated at the Texas Health Presbyterian Hospital and from patients and residences in Texas, these special permits are limited to the transportation of waste generated in Texas to disposal facilities. On October 15, (FIMMAD) issued a non-state specific permit for which there are currently seven grantees. On October 24, (FIMMAD) issued the first revision for which there are currently seven grantees.

On October 24, (FIMSAD) issued the first revision of the non-site specific special permit to authorize transport of (contaminates) by vessel as well. (FIMSAD) has also posted procedural guidance for hospitals and transporters on the proper packaging and transport of suspected Ebola laced as well as an FAQ guidance document available on (FIMSAD)'s Web site on [www.phmsa.dot.gov](http://www.phmsa.dot.gov).

It is important to note that the transportation of hazardous materials in commerce is regulated by the HMR but the disposal of the waste is not. The HMR covers the packaging, loading, transport, and unloading of packages contaminated with suspected Ebola waste but do not cover the disposal process. Once waste is autoclaved or incinerated it is no longer a hazardous material subject to the requirements of the HMR.

For more information, you can contact (FIMSAD)'s info center. That number is 1-800-467-4922. The information center is open Monday through Friday from 9 am to 5 pm. And that's all I have. I will turn it back over to you. Thank you.

Gregg Margolis: Well thank you very much. Now we would like to turn things over to your questions. In addition to our speakers I would like to introduce a couple of other panelists who will be joining us for questions that you may have. Sean Cavanaugh is the Deputy Administrator and Director for the Center for Medicare and Medicaid Services and Dr. Matt Heinz is the Director of Physician Outreach for HHS's Intergovernmental and External Affairs.

So at this point, we would like to ask the operator to provide instructions on how you can log in and ask questions of the panelists and we look forward to your questions.

Coordinator: Thank you and at this time if anyone would like to ask a question, please press star 1 on your phone. Unmute your phone and record your name clearly when prompted. Again, for any questions, please press star 1. It will take a moment or so for questions to come through.

Our first question is from (Lisa Lavoy). Go ahead your line is open.

(Lisa Lavoy): Hi my question is about the rapid response team that you mentioned earlier that would be sent to the facility that has an Ebola patient. Several questions related to that. Number one, will this team be sent whenever it is confirmed that this patient does have Ebola based on lab testing or if the (admission) is high and we are waiting for the results to come back. And second, what is the estimated time it takes for this team to be deployed so we can plan on how

long we would need to house this patient before the patient will be sent to a treatment facility.

Gregg Margolis: Arjun do you want to take that.

Dr. Arjun Srinivasan: I can't answer that in great detail. I think that the situation you know obviously remains in evolution. I think that there is always close contact between public health both at the state, local, and national levels. And so, there is not a rigid no team will be sent until the test becomes positive policy that I know of. My understanding is that the decision to send these teams is based on discussions and what is useful and helpful at the local level. And so, you know we remain open. We want to have discussions with folks when folks come and present for care.

When there is a need to perform testing. We are ready and willing to send folks to come and help with the management. Whatever the situation calls for, so there is not a - you know no one will come. There is not a policy I don't think anyone has said. No one will come until a test comes back positive. There is always a discussion between public health at all of the levels.

(Lisa Lavoy): Yeah so it is Dr. (Lavoy). I might add a little bit to that. I mean the goal is to be sure that hospitals feel that it gets the help it needs. You know we have only had one situation like this so far which was the physician in New York. And what I can tell you about that is even before the test was back. It was a strong enough suspicion that his test would be positive, that the team got on the plane and flew to New York. And they were there not very long after the test was positive. So it is very much a goal to be there as soon as possible when needed.

I will also tell you that, you know, numerous times a day, we have reports now of people who come into a facility who have a fever and who get isolated and then there's a consult with the CDC. Many of those people don't require testing at all because they haven't had any exposure. And sometimes, there's a lot of confusion about which countries are affected or what the time course is or others.

But there are people who are getting tested every day. And so far, all of those who have been tested other than Dr. (Spencer) in New York have been negative. So it's not practical to send a team for these - you know, these patients who we think are low-risk and there's a really ready explanation for their illness otherwise.

So it's going to be on a case-by-case basis. And then, in terms of how quickly will people be there, Atlanta's a pretty big hub. So getting out of Atlanta's pretty easy. There are some places in this country that are harder to get to than others as I think you know.

And so there's not a set time. But I think you can feel very reassured that someone will be on the phone with you for as long as you need it to help breeze through a plan while you are waiting anything more definitive. We think the chance of people walking into a hospital and a remote area of the U.S. is exceedingly small or people walking in with Ebola is exceedingly small.

Coordinator: Our next question is from (Kit Carrington). Go ahead; your line is open.

(Kit Carrington): Hi, this is (Kit Carrington). I'm calling from Medical Center in Watertown, New York. We are very close to the Canadian border. And I had a friend who just went up for a concert up into Canada into Ottawa. And the first question

they were asked at the border was the screening questions about travel and signs and symptoms of Ebola.

However, when they returned, there were no such questions asked. My question is is that being entertained? We have many, many travelers who come from other countries who come into Canada and then they drive down.

And we have several people who work back and forth to different hospitals.

Woman: You know, it's a really good question. And what I can tell you is that, like the United States, Canada has also a very strict entry screening procedure. So people coming into West Africa to Canada, I think, would be identified and detected in that way.

I think, in addition, it's fair to say that people are looking at whether anything else needs to be done to tighten screening at the borders; maritime screening is in place, etcetera. So, Arjun, I don't know if there's anything else you want to say about that.

Dr. Arjun Srinivasan: No, I don't; thank you.

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

(Laurie Fredrick): Yes, hi. I'm calling from (Mary Washington) Healthcare in Virginia. And the question we had was we've seen and drilled the gut, donning and doffing. But we haven't seen it with the (papper) in place.

I'm wondering if that's out there and we're just missing it. The other question is guidance on how to clean the (pappers).

Dr. Arjun Srinivasan: This is Arjun. Yes, we've collaborated - CDC has collaborated with the Armstrong Patient Safety Institute of John Hopkins Hospital to produce some videos on the donning and doffing - putting on and taking off sequences.

For both options, there's currently a video up with the N95 option. But as you pointed out, there's not one for the (papper). There is one forthcoming - should be forthcoming very soon - it will be available on the CDC website - that shows a video for the (papper).

In terms of cleaning the (pappers), that is each manufacturer has its own recommendations for how you would clean those, what cleaning materials are compatible with their (pappers). And so that's something that you should discuss with the manufacturer of whatever brand of (papper) that you might be using.

Coordinator: Our next question's from (Jane Cooley). Go ahead, you're line's open.

(Jane Cooley): Yes, this is (Jane Cooley) from Western New York Healthcare Association in Buffalo, New York. I'd like to ask Christina to repeat the website that she gave about procedural guidance of the contaminated waste in the DOTOH - or DOT - excuse me.

Christina Tackett: Sure. That website is [www.phmsa.dot.gov](http://www.phmsa.dot.gov).

(Jane Cooley): Thank you very much.

Christina Tackett: You're welcome.

Man: And we have a link to that website also from [phe.gov](http://phe.gov). PHE - [PublicHealthEmergency.gov](http://PublicHealthEmergency.gov).

(Jane Cooley): I appreciate it; thank you.

Coordinator: Our next question's from (Livvy Fasser). Go ahead, your line is open.

(Livvy Fasser): Well that was a great lead-in to my question. I wanted to know what time zone that phone number was - well - and the hours of operation were 9 to 5 but what time zone?

Christina Tackett: That's Eastern Time.

(Livvy Fasser): Thank you.

Coordinator: Our next question's from (Lynn Hepkin). Go ahead. Your line is open.

(Lynn Hepkin): Hi, this is (Lynn Hepkin). I'm in Southwest Wisconsin at Oakland Hope Health. My question is do you have any recommendations for the non-Ebola-treating hospitals on the approach or extent of testing expected on our part to test for or rule out other infections such as Malaria because we are trying to decide if our laboratory would have much involvement in a patient that we might have in the ER and trying to make our plans around that.

Woman: Well, so, I would suggest that that's something that would be good to work with the State and Local Health Department around. You know, when people come in and they have a fever and they're ill, it, you know, yes you can rule out Ebola, but there's still then an expectation that you're going to have to figure out what's wrong with them and either where to - where they need to be transferred for treatment or treatment itself.

It is the case that Malaria is a very frequent cause of fever and it is one of the most frequent causes of fever in people coming back from these West African countries. So that might be a consideration for you. I don't know if anyone else from CDC wants to add more to that.

But this is an area where I think your health department could give you great advise.

Dr. Arjun Srinivasan: Yes, this is Arjun. I agree and I think that, you know, the care of patients, you know, I think that if you have travelers who come to your emergency department who, you know, are returned from this part of the world, Malaria testing is obviously a consideration.

Whether or not you need to bring Malaria testing on, I'm not sure if that's what you're asking about. You know, I would say that you need to do what you need to do to evaluate patients who are returning from these areas, almost none of whom will have Ebola.

Most of them will have something else. And so if your hospital sees a lot of these folks, then, you know, in consultation with - as Dr. Lurie's - just your health department and your infectious disease staff at your hospitals, you can determine what the right tests you need to have on-hand to be able to evaluate patients if they're - if these are folks who normally come - present to your ED for care.

Woman: Thank you.

Coordinator: Our next question's from (Deb Lonar). Go ahead, your line is open.

(Deb Lonar): Yes, I just had a question. What is the rationale about having the buddy available in donning the PPE - not in doffing, but in donning?

Dr. Arjun Srinivasan: This is Arjun. The recommendation there is not so much for a buddy, it's for an observer. And the key is that we want to make sure that when you put on your PPE that you've done it exactly correctly and that when you've finished, it's done right, it's on correctly, and that you're able to move around and do what you need to do without the PPE - having the potential for a...

(Deb Lonar): Okay.

Dr. Arjun Srinivasan: ...breach in any way.

(Deb Lonar): I thought it was...

Dr. Arjun Srinivasan: And so that's why we recommend that both the donning and doffing procedures be watched by someone very carefully.

(Deb Lonar): Okay. I understood it to be that the buddy had to be also garbed for the donning procedure.

Dr. Arjun Srinivasan: Oh, no, no. For the donning, the observer doesn't have to be wearing PPE.

(Deb Lonar): Okay, very good.

Dr. Arjun Srinivasan: Yes.

(Deb Lonar): Okay, thank you.

Dr. Arjun Srinivasan: Yes.

Coordinator: Thank you. Our next question is from (Angie Kenisoshi). Go ahead, your line is open. (Angie Kenisoshi), your line is open.

(Angie Kenisoshi): I want to know if there are restrictions for a healthcare worker who's caring for a potential Ebola patient. Like, are they allowed to care for other patients? Are they off of patient care for 21 days other than just that Ebola patient?

Are they allowed to go to the cafeteria in the hospital? Those kind of things.

Dr. Arjun Srinivasan: This is Arjun. That's - that issue is covered in our - the movement in monitoring guidance that CDC has prepared. And yes, those folks could care for other patients, provided that there's not some sort of a - well, first of all, if you're talking about, you know, a suspect case, obviously, if they're not confirmed then there's no issue.

If there's some sort of a breach in the protective equipment for a known case, then there are some additional issues that come into play. And those are also detailed in the movement in monitoring guidance. But yes, those healthcare workers can care for other patients.

(Angie Kenisoshi): Okay, thank you.

Coordinator: Our next question's from (Susan Kramer). Go ahead, your line is open.

(Susan Kramer): Hi, my question is when - say, a possible Ebola patient comes into your ER waiting room. We mask them, we whisk them right into a isolation room. What would be your recommendation as far as cleaning that waiting room?

We have other people in there, we want to get that Ebola patient we know out of the general population as quickly as possible. But would there be specific cleaning other than what we normally do after that occurs?

Dr. Arjun Srinivasan: This is Arjun. No, there wouldn't be unless the other person was having vomit or - had thrown up or was having diarrhea, and had an accident there. Otherwise, it would be the standard cleaning protocols.

(Susan Kramer): Thank you.

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

(Debbie): Yes, I work at a health center which is a provider's office. And we're struggling with fighting good guidance on what our PPE protocols should be.

Dr. Arjun Srinivasan: This is Arjun. We are working on guidance for ambulatory care settings. And we hope to have that guidance issued very, very soon.

(Debbie): Okay, so in the meantime, we're using Tyvek suits, face shields, regular surgical masks because we're not fit-tested. Is it appropriate to go ahead and start that training in the meantime?

Dr. Arjun Srinivasan: You know, it depends on your ambulatory care center. You know, the - if you look at the guidance for emergency departments, there are options for protective equipment as I discussed based on what patients - what kind of symptoms patients have.

So, you know, if you are an urgent care center where you get walk-ins and you do have patients who might have traveled to this area and might have symptoms or might have, you know, vomiting and diarrhea, then yes. Some

training for a limited number of staff who might have to interact with those types of patients would be appropriate.

If you're an ambulatory care center where people only come to you after making telephone appointments, then, you know, this may not be an issue for you because, you know, you might not be equipped to manage those patients. And so, you know, that's a situation where you can do some triage over the phone.

But it sounds like you're more - your setting is a little bit more akin to an emergency department if I understand it correctly.

(Debbie): Yes, we have some urgent care. And then, in areas, well - we have multiple centers. But in some of our places where we don't have urgent care, we do get some walk-ins.

Dr. Arjun Srinivasan: Right. So, you know, I think if you provide care that's kind of more emergency department-like, then you could follow that emergency department guidance.

(Debbie): Okay, thank you.

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

(Bess Belton): Hey, I'm a physician at (Center Health) in Duluth Minnesota. A few of the things that you've recommended I think we've done already, you know, the idea that we're a larger facility that is having our smaller facilities and usual referrals from even out of state come to us.

And so any PCR testing from our local facilities, the patient will be transferred here; we'll watch them here, you know, identify (isolate) and involve public health as much as we can from our facility for them in order to limit the number of individuals that need additional training or to be prepared to take care of and provide care for a patient who is sick that is at some risk. And I realize that we can sort of the what-ifs all day long.

This is a question that has come from multiple facilities though, so I'm just looking for a little guidance. And if you want to refer me onto somebody else that would be great. I have talked MDH about some of other things.

So if a patient, it's unlikely, but is unstable and presents to a smaller hospital where they're not doing point-of-care testing, and really, what you want is hemoglobin and some electrolytes on a very sick patient. Those hospitals, again, are not really - they're not able to do that.

And when do we start saying that's okay to change the standard of care on a patient who hasn't yet and is unlikely to have Ebola but is a risk?

Woman: So I think it would be important, as you have to talk to MDH, you know, I think that you can do those basic testings as long as your laboratories done a risk assessment and follows (blood-born) pathogen guidance. But I think you would want to get additional guidance from MDH.

(Bess Belton): Okay, thank you.

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

(Neil Catchaleo): Hello, this is (Neil) from (HL System), Houston Texas. And I have two questions.

One is if a patient comes through our emergency room or an annual D&T point, and they're classified as one of the risk patient. Are there any guidelines for PP for the left stuff (sic) to follow through at that time or do they need to have the same extensive PP and see if the patient has been effected with Ebola because that expose to blood; that's number one.

And number two is that we have acquired a few comments that are floating around in the lab community where the vendors are stating that if you happen to run the Ebola patient's specimen in our instrument, they will not take it back for maintenance or whatever it is. So they may need for some education on vendor side too. So those are the two questions I have.

Dr. Arjun Srinivasan: This is Arjun. I think the key to remember, as someone was just pointing out, you know, there's not guidance for every scenario that we encounter.

One key thing to note is that, you know, my understanding in talking to a handful of the places that have dealt with these potential cases is that the vast majority of them, an alternate diagnosis is made without any sort of testing. It's largely based on the history that's given. So I think that is really important.

So if the history is concerning for Ebola and lab testing needs to be done, then I would suggest that the lab staff follow the guidance that has been issued for laboratory workers who might be working with specimens with Ebola. So I think that's something that, you know, it depends on the circumstances of the cases.

But you know, what is really key I think in these settings is to emphasize that the history is so important here. And before any of the testing is done, it's important to obtain the history and understand what the risk really is.

And we've heard the same issue on the laboratory equipment and agree, you know, there is certainly a need to educate folks about this. And so that is something that I think has been ongoing discussions with the laboratory community.

(Neil Catchaleo): Thank you.

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

(Sandra Cole): Yes, I'm calling from New Mexico. And my questions concern what occurs with decedents. I know that the embalming is not considered but we're trying to put a plan together here and I'd like to know how it was handled in Texas.

Woman: So CDC has guidance on fatality management for patients with Ebola and it is posted on their Web site.

(Sandra Cole): Yes, it's pretty general. Is there nothing more specific than that then?

Woman: So I think it's probably fair to say that if you had a patient with Ebola, there would be the opportunity to consult with the CDC hopefully while the patient is still alive.

My recollection about this is that the patient in Texas was cremated and that there was a plan that was worked out with the Texas Department of Health and the Coroner's Office for that.

(Sandra Cole): Okay, that's good. That's what I was wondering.

My other question if I may ask a second one is with regard to hazmat companies that clean the Ebola patient residence. Our hazmat companies in the state are not open to doing that. So it sounds as though (unintelligible) companies in Texas and it sounds as though everyone is contracting with them.

Is that the case? Have other states not had has much trouble as we're having here?

Dr. Arjun Srinivasan: This is Arjun. I don't have any information on that.

(Sandra Cole): Okay, thank you.

Man: Are you referring to the waste hauling or are you referring to the cleaning of non-healthcare facilities?

(Sandra Cole): The cleaning (unintelligible). Yes.

Man: Yes, I believe that a large multi-national or multistate company that accomplished that task.

(Sandra Cole): Actually no, they were both - both of the ones were in Texas; they were Texas companies. And it sounds as if I spoke with one of them the other day and they've contacted with 15 other states. And I know that if we all need them at once, that's not going to be a workable situation.

So I was just wondering if you had any more information on other companies that might be available.

Man: We - that would likely be an EPA issue. But - and I don't have any additional information about other companies that might be able to do that in the event that we had concurrent need.

(Sandra Cole): Okay, thank you.

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

(Jackie Blanchard): Hi, good afternoon. This question actually tails off of the outpatient facilities. Arjun, this question is going to be for you, and thank you for letting us know that guidelines will be coming out soon for those areas.

In the interim, I work for the Atlantic Health System which is in New Jersey; we're very close to two major airports Newark and JFK.

So in the interim, what guidance can you provide for the outpatient facilities, ER centers, outpatient programs that don't have the same resources, PPE, and certainly no isolation rooms that we are equipped with in patient and acute care emergency room side? Thank you.

Dr. Arjun Srinivasan: Thank you, yes.

So, you know, what I would say is, you know, if you're an urgent care center and you kind of function as an emergency department where, you know, people might come in then, you know, I think you need to think about your patient population and look at the ED guidance and make some decisions about what types of PPE you might need to have on hand, you know, if that's your setting and you kind of serve as an emergency department.

If you're ambulatory care center and you don't have a walk-in and people have to have appointments to come to you, then, you know, what I encourage people to do is really use the telephone as part of your personal protective equipment. Ask the screening questions over the phone so that you know if the person has those risk factors before they make an appointment. And if they do, and you know, you're not equipped to do that type of evaluation, that's when, you know, you can touch base with public health and try to find out where might be a more appropriate place for that person to go.

(Jackie Blanchard): Thank you.

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

We have a question from (Spencer Grober). Go ahead, your line is open.

(Spencer Grober): Thank you. The CDC had talked about an assessment tool and various (unintelligible) was looking at that would bring up to hospitals who were interested in getting a consult and being maybe the stepping up for the certain states.

Is it that tool available that we can now start giving to those hospitals so they can prepare for a CDC onsite consultation?

Dr. Arjun Srinivasan: This is Arjun. There are, you know, various tools and resources that are being used by the public health and the hospitals. And you know, a lot of these are being discussed and shared, you know, as these facilities are chosen.

This is obviously an evolving situation and so the tools are changing and may change, you know, based on interactions and discussions with the hospital that's going to be visited. And so this is something that, you know, as the

discussions begin between public health and the hospitals who might be interested, materials are shared back-and-forth in order to facilitate that visit.

(Spencer Grober): Thank you.

Coordinator: Our next question is from (unintelligible).

Man: Operator, I think we have time for one, maybe two more questions.

Coordinator: Okay. Our next is from (Jonnie Hobmister). Go ahead, your line is open.

(Jonnie Hobmister): Yes, I'm calling from a laboratory in Washington State. And we are working to equip our critical care unit with point-in-care tests that they complete should we have a positive Ebola patient present.

The question would be if the physician desires more extensive testing than point-of-care that we can provide, what should be our next course of action?

Woman: You know, I think the general answer again would be to consult with your State Health Department. But in general, I think it's to perform a risk assessment and do testing that is consistent with all of the blood-borne pathogen standards.

(Jonnie Hobmister): Okay, thank you.

Man: With that question, we have come to the end of our hour.

I would once again like to thank all of you for joining today and remind you that the transcript and audio recording of this session will appear on PHE.gov

within the next 48 hours or so. And I'd also invite everybody to send questions that we may not have gotten too to (Asper) at HHS dot G-O-V.

And with that, I'll thank all of you for your time and participation in this teleconference. Have a nice weekend.

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

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