

Preparing Your Healthcare Systems for Ebola

Moderator: Ingrid Caples

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2:00 pm CT

Coordinator: Good afternoon and thank you all for holding. Welcome to the Preparing Your Healthcare Systems for Ebola conference call. Your lines have been placed on a listen-only mode until the question and answer portion. If you would like to ask a question please press Star 1.

I would like to remind all parties the call is now being recorded, if you have any objections please disconnect at this time.

And I would now like to turn the call over to Dr. Brendan Carr. Thank you, sir, you may begin.

Brendan Carr: Thanks very much and hi, everybody. Good afternoon. Thanks for joining us on a Friday afternoon and thanks especially for taking time to make sure that we prepare our healthcare system for Ebola.

My name is Brendan Carr. I'm the Director of the Emergency Care Coordination Center in the Office of the Assistant Secretary for Preparedness and Response.

We're holding this call today for two reasons really; the first is to make sure that you are up-to-date on information, and the second is to make sure that we listen to and address questions and concerns that are remaining.

Just as the operator suggested, this is a recorded call. A transcript and recording of the call will be made available. It will be placed on the webpage phe.gov. You'll see their other calls that have been held for other stakeholders along with their transcripts and the audio recording.

You should note that on [page e.gov](http://page.e.gov) there are lots of other resources about Ebola. There are also lots of other resources about Ebola on the CDC's Website.

We have, today, assembled a group of leaders across the Department of Health and Human Services that are working on different components of Ebola response. Specifically today the Assistant Secretary for Preparedness and Response, Dr. Nicole Lurie; we have the Director of the Division of Health System Policy, Dr. Gregg Margolis; and we have the Acting Deputy Director of the Division of the National Healthcare Preparedness Program, Melissa Harvey.

From the CDC we have Dr. Arjun Srinivasan and Dr. Sridhar Basavaraju. And they will both explain in greater detail as we march forward their roles at CDC.

For starters, it's my pleasure to introduce you to Dr. Mike Gerardi, who I know the listeners on this call know. He is the current president of ASP and he wanted to provide a couple brief remarks before introducing Dr. Lurie.

Mike Gerardi: Thank you, Brendan - Dr. Carr. It's really great to be on this call. As you know the Ebola outbreak has really created a new spotlight on emergency departments. It highlighted a couple of things, number one, our critical role in disaster preparedness and being the frontline but it also points out that we aren't as well equipped as would like to be with regard to staff and education and what not.

Now last month I had the pleasure of two meetings, help set up by Dr. Carr, with Dr. Lurie and her staff. And I just want to introduce this call by letting you know that she and her office understand what we're going through and what ever needs are, that they need this call occurring today because they need to hear from - than just me, our other representatives.

But I think - I'm not going to steal Dr. Lurie's under but I do want to tell you I think you're going to like what you hear. What I've met with Dr. Lurie and her staff is they are committed to giving us the resources we need to educate ourselves to handle Ebola and other infectious disease threats.

But also they're really mentioning a lot about a sustained effort to improving the infrastructure for emergency departments for disaster preparedness. So I don't want to take any more of Dr. Lurie's time but I just want to really express my appreciation and please, folks on the call, please interject with questions when the time presents itself. Thank you. Dr. Lurie.

Nicole Lurie: Good. Hi, and thanks so much Dr. Gerardi and hello to all of you on a Friday before Thanksgiving week. Appreciate your being on. I want to first I want to first start by thinking emergency care providers all over the country for the work that you do every day to be sure that our healthcare system is ready to respond when a disaster strikes.

And of all the different kinds of people in the healthcare system I think you uniquely understand that mission and that role. You know, around here we always say that good preparedness and good response is built on the back of strong day today systems.

And the situation with Ebola is like no other in that regard. In order to do a good job with this, as we need to do a good job with everything else, we need to be sure that their day-to-day systems are strong and intact.

And, you know, you on the phone and many of your colleagues in this regard are really our first line of defense here. And so you're strong day-to-day systems really translate into more health security for our country.

But I think you've heard many times before, that a large-scale Ebola outbreak in this country is extremely unlikely because we have strong healthcare systems; because we have made significant progress in quality and safety; and because we have a lot of experience with infectious diseases and infection control.

That it is fair to say that Ebola has raised lots and lots of concerns, both amongst the public and amongst healthcare workers specifically for front-line providers at home and abroad. And it's those concerns I'm hoping that we can really address and answer your questions about today.

I will tell you that across the federal government we are really taking a whole-look government approach, both responding in the US and responding in West Africa. And in fact I'll have to leave this call early to go over to a call with the national Ebola Coordinator, Mr. Klain.

I think in terms of our strategy here and our preparedness efforts a lot of our preparedness efforts here in this country now, in addition to strengthening the public health system and ensuring that there is good surveillance and good laboratory capacity, is to strengthen our healthcare system.

I thought it might be worth just a moment to go through what the system is now for keeping track of patients who are coming to this country from West Africa. Because it's an unusual set up and it's not something that we've done this comprehensively around this much detail before.

But as I suspect many of you know now, all travelers that come to this country from four affected countries, Liberia, Sierra Leone, Guinea and now Mali, are being funneled through five major airports in the country.

In those airports they get screened by Customs and Border Patrol. And if there is anything that makes those folks think they need additional screening, if they've been in contact with an ill person, attended a funeral, taking care of Ebola patients, have a fever, they then are passed over to the CDC quarantine folks who continue to evaluate them. And if there are still concerns they're evaluated in a local hospital.

From there the contact information for every single one of those travelers is given to the CDC and they in turn pass that on to the state that the traveler is going to. And the state health departments all over the country now are in the process of monitoring for 21 days each of those people, recording their temperatures twice a day, talking to most of them about a symptom checklist as well.

And if any of them get a fever or have concerning symptoms they will be directed by the local health department to an emergency department that is

known to be prepared and ready; that's trained, has staff, has adequate PPE. And they will be transported by an EMS system that is also trained and ready and that has PPE.

So we are feeling as though much of the system now is a pretty good closed loop. There's probably - I think we all believe more room to go in that regard. And obviously we all remain concerned about the person who wakes up in the middle of the night, get sick and doesn't really think to call their local health department first and just shows up. And I think from that perspective we all need to be very vigilant.

So our health-care preparedness efforts are focused in a couple different areas. First of all, we believe that every hospital in America has to be sort of a front-line hospital and is fight to keep our country safe from Ebola. And all front-line health-care providers, including all of you on the phone and your friends and colleagues, it need to think Ebola.

And that means if you have a patient that comes in with a febrile illness or symptoms compatible with Ebola, GI distress - and I know that it's flu season - or if you have a patient that comes in febrile, you need to take a travel history and if they've been in one of those countries in the last 21 days you need to really be suspicious and think about Ebola.

So we're working with front-line providers all over the country. We've had enough calls now that we've reached 360,000 people, so that people will know how to identify, how to isolate a patient. So we would want you to put that patient in a private room, preferably with a bathroom, and call your local health department and particularly if they're stable, that's relatively straightforward to do.

In addition, we are establishing a network of treatment facilities around the country that are in the process now of getting themselves prepared through training, through exercises, through a very careful checklist of activities largely pertaining to infection control; through a visit with the CDC and their state and local health officers to determine if they are ready to take care of Ebola patients.

And the number of those hospitals have already stood up and declared that, you know, they are ready and willing to do this. And then finally, many states are designating and identifying additional facilities that they will direct patients to if they have somebody who might be a (rule-out) Ebola patient.

So I guess about what's going on on the front-end. I think certainly previously I heard from Dr. Gerardi and many of your colleagues about issues; getting personal protective equipment at the frontline of medical care. And I want to say just a couple of quick words about that.

You know, first of all I will say that as the CDC's revised guidelines came out, there was a fair amount of sort of panicked ordering and panicked buying. And there are certain kind of personal protective equipment that are in short supply.

We have been working a lot with the manufacturers and distributors and hospitals that are ready to take care of Ebola patients and are unable to get that PPE that they think that they need, can be on a list and we can work with them to preferentially get material to them.

That said, it also has seemed like a lot of facilities have sort of forgotten basic principles of emergency management when it has come to getting PPE. Since you guys are all emergency managers I doubt this applies to you.

But just to remember that, you know, the first thing you ought to do is check with your purchasing coalition. And then in almost all of your communities there is a healthcare coalition funded by the Hospital Preparedness Program. The healthcare coalitions very often have a good handle on where all the supplies are in a community and are in a position to help you access it.

If you can't access it through those channels then we would want you to be in touch with your state. And if your states can't get you what you need they can be in touch with the Strategic National Stockpile. The Strategic National Stockpile now has enough PPE so that if you had a patient with Ebola they could, within 12 hours, get enough PPE to your facility to take care of a patient through the entire course of illness.

So I want you to know that and be reassured that there is a system in place that increasingly is not going to leave folks, you know, shorthanded and unprotected when it comes to personal protective equipment.

Finally, we are working with Congress on funding. And on November 5 the President submitted in emergency funding request to Congress for the Ebola outbreak.

And the strategy for this emergency funding request is really built on four core principles. One is about domestic preparedness and it includes being sure that we can have a facility to take care of any bowl locations in every state strengthening our domestic preparedness and also buying personal protective equipment at the healthcare coalition level.

But I got to say we cannot ensure the safety of our country unless we stop the outbreak in West Africa. And a large part of our effort now is aimed at doing just that.

I've noticed that Ebola slipped off the front pages of most newspapers most days. I want to make sure you understand that doesn't mean it's over; there are still 1000 to 2000 new cases and week of Ebola in West Africa. And we cannot rest until, you know, all the embers are really put out there.

Third, we are investing in new vaccines and therapeutics. And vaccines will go into clinical trials in West Africa in December. And then finally, investing more in global health security so that we don't end up in a situation again where there's a huge outbreak like this that goes out of control and unrecognized for a long time. So leaving a system in place that prevents this.

So the emergency funding request would let us execute this strategy and see it through and it has a lot I think for emergency physicians in terms of strengthening the institutions that you work in and the overall emergency preparedness system. So we may continue to see a couple of imported cases -- or a handful of imported cases -- over the coming months as we work to get this under control in West Africa. I have a high degree of confidence that we're not going to see a large scale outbreak, but that means that we all need to be on our guard and it means that you all need to be on your guard.

So I will close again by thanking you for all you're doing in that regard and I'll turn this over to my colleague Dr. (Unintelligible) from the Infection Control program at CDC.

Man: Thank you so much Dr. Lurie. We appreciate being able to join the call and to talk with all of you. We have - you know, we'll provide a very brief overview

of the current guidance for evaluation and management of patients with possible Ebola Virus Disease in the emergency department. And then we will leave lots of time - lots of time to answer any questions that you all might have.

Dr. Lurie mentioned the strategy for preparedness I think is evolving in the United States. And we're building that strategy on this more aggressive monitoring and movement guidance that we have developed at CDC. As Dr. Lurie mentioned, all of the patients who have potential risks -- be they travelers from West Africa or healthcare workers in this country -- are being directly monitored by the health departments. And so the chance that someone's going to unexpectedly come to an emergency department, I think is becoming very, very unlikely. And that's a good thing.

Nonetheless, we know that emergency departments do need to be prepared to potentially evaluate and provide initial management for a patient who might have Ebola Virus Disease, but I think it's important to think about the likelihood of this happening in your region and how often this might happen in your region and in your ED when you're thinking about planning. And in particular when you're thinking about the supplies of protective equipment that you might need to have on hand and the number of staff members that you need to really train in how to use that protective equipment.

Many EDs I think would reasonably encounter a very, very small number of these patients, and so your supplies for PPE should reflect that kind of assessment that you would do. And that could be done, you know, in conjunction with your state and local health department to understand the number of patients in your area who are being monitored. So I think that's a key consideration as you're thinking about how you might plan.

We do think it's important that, you know, if there is even a chance that you might have a patient who could have Ebola present to your emergency department that you of course need to have a plan for how you might manage that person. There are a number of key components that you would need to keep in mind and bear in mind as you develop that plan. We do recommend -- that -- as a key component of the plan -- that you have an onsite facility manager -- a designated person -- who thinks about your Ebola management plan and who has the primary responsibility for developing and executing that plan so that there is a single individual who thinks about the planning and the preparedness of an Ebola management plan.

There are a number of key considerations that we've - we think need to go into that plan. You need to think about the triage considerations; how you provide safe triage. A plan for where you would put a patient; so patient placement. A plan for where the healthcare workers would put on and take off the protective equipment. Some plans for providing a very limited number of your ED staff who might care for one of these patients, the plan for training those staff on all aspects of providing care. So in particular, putting on and removing protective equipment. Planning for the necessary supplies, especially the protective equipment that you would need. Considerations and planning for lab testing, plans for environmental cleaning, and plans for waste management.

And what I'm going to do now is turn it over to my colleague Dr. (Unintelligible) who is himself a practicing emergency department clinician who really led the development of the kind of triage and initial assessment algorithm for Ebola - potential Ebola Virus patients in emergency departments. So Dr. (Unintelligible).

Sridhar Basavaraju: Thank you. So this algorithm was actually developed in collaboration with both ASEP and ENA. And the goals of the algorithm are to facilitate

identification of patients who might be at risk, appropriate isolation, as well as informing the appropriate local health department and infection control staff. So the first step in the algorithm is to identify an exposure history. And this we would recommend would be done at triage or otherwise the first contact with the emergency department. And that would be just asking the patient whether they have lived in or travelled to a country with widespread Ebola transmission within the previous 21 days or if they had had contact with a person who had confirmed Ebola virus disease in the last 21 days.

If the answer to that is no, then we suggest just going on with the usual triage and assessment with no further measures for Ebola. This - if they answer yes to the exposure history, then we would have to identify if the patient has signs or symptoms that might be compatible with Ebola. And that would be a fever at - greater than 38 Celsius and the other symptoms would be headache, weakness, muscle pain, vomiting, diarrhea, abdominal pain, or hemorrhage. If they answer no to that, then the usual triage and assessment could continue, but the relevant health department should be notified of the patient's history so that the patient can be monitored for 21 days after the last exposure to see whether - to rule out that they're developing Ebola.

If they answer yes to any of those symptoms, then the appropriate isolation and determination of PPE would be needed. So the patient should be placed in a private room or separate enclosed area with a private bathroom or a covered bedside commode. And from that point forward, only essential personnel who had previously designated roles should evaluate the patient and provide care to minimize transmission risk to healthcare workers.

And the use of PPE should be based on a patient's clinical status. So if the patient is exhibiting obvious bleeding, vomiting, diarrhea, or if they have a clinical condition that would warrant any invasive or aerosol generating

procedures such as intubation or suctioning or active resuscitation, then the PPE that is designated for the care of hospitalized patients should be used. And if the patient does require active resuscitation, that should be done in a pre-designated area using pre-designated equipment.

If the patient does not have any of those symptoms, then the PPE that's recommended would be a face shield -- surgical face mask -- impermeable gown, and two pairs of gloves. But if the patient's condition changes, then the need - the type of PPE should also be reevaluated. So once the healthcare worker has done the appropriate PPE, then the history of visible exam should commence. And the decision to test for Ebola should be made in consultation with the health department. Back over to Arjun.

Arjun Srinivasan: Yeah, so a couple of things. I think that Dr. Basavaraju pointed out, you know, we've heard from a lot of emergent departments that one of the things they've found helpful is, you know, even outside the ED they have signs there that ask patients to self-identify if they have particular exposure, risks, travel histories -- that kind of thing -- as yet another even earlier screening measure, even before they get into the triage area.

And the other thing that's important I think that he was emphasizing is that there are two different types of protective equipment that are recommended depending on the risk assessment here. And I think that bears special relevance because as the monitoring system that we have in place encompasses all of the patients, we are able to get those patients referred in at an earlier stage. So I think that the chances that you'll encounter a patient -- particularly one that might be say referred from the health department -- they are more likely to be at this very early stage of infection, because we're referring those patients at the first moment when they begin even having, you know, subjective fevers or not feeling well.

So the option for the PPE that's not the full hospitalized version of PPE -- the one where you can do a face shield, a mask, a gown, and gloves -- might become more and more commonly used in the emergency department setting. And I think that's a good option to have there. And I think the final thing that I'll just mention in closing is of course that a very large number of patients have been evaluated in emergency departments in the United States for possible Ebola Virus Disease. And we know that, you know, only one of those patients has actually be diagnosed with Ebola Virus Disease who came through an emergency department.

So the overwhelming majority of these patients, of course, are not going to have Ebola. They're going to have something else that you'll have to provide care for. And once Ebola has been excluded, then you can proceed as you normally would. So all of the issues with environmental cleaning and waste management that can be so challenging for Ebola are not an issue anymore, once that diagnosis has been ruled out. You can provide care as you usually would, manage the waste as you usually would, and clean the environment as you usually would.

And with that, I think we will stop and turn it back over to Dr. Lurie or others on the call and we'll stay on for questions. Dr. Lurie.

Man: Dr. Lurie just left to go meet with the - Mr. Klain, unfortunately. But I think we want to open up the phone to questions now if we can do that, Operator.

Coordinator: Thank you. At this time if you would like to ask a question, please press Star 1 on your touchtone phone. You will be prompted to record your name. Please un-mute your phone and record your name clearly when prompted. Once again, to ask a question, please press Star 1. One moment, please. And once

again, if you would like to ask a question, please press Star 1. One moment, please, for the first question. Once again, to ask a question please press Star 1. Please un-mute your phone and record your name clearly when prompted. Sorry, I am showing no questions at this time.

Man: Very good. So, you know, we're happy to leave the call open to talk with the CDC or to talk with Dr. Margolis or Ms. Harvey about any of the programs happening CDC or ASPR or if there are no questions we are also happy to end the call. We give this another two minutes, Operator. If nobody's got anything, then I just would say thanks everybody for being onboard today. Thanks for...

Coordinator: Sorry, I do have a couple of questions. And our first question today is from (Gary).

(Gary McKay): Hello. Hello?

Coordinator: (Gary), your line is open. Go ahead with your question.

Arjun Srinivasan: Hi (Gary), we can hear you.

(Gary McKay): Okay. I'm (Gary McKay) from Community Hospital in Munster, Indiana. As you -- I don't know if you remember or not -- we're the hospital that the first case emerged in the United States, so we're very familiar with the obstacles. I think we are all set; we have most of the things in place that you've provided to us today on the telephone. My question is, will there be a time where hospitals and areas will get a number of people under surveillance -- not particularly the names -- but just a number of people so hospitals can be prepared that there are people in the area that might be under quarantine?

Arjun Srinivasan: Yeah, I think that's a really good question and I think that's something to work with your state and local health departments on. I think it's a good idea to have that type of situational awareness. It would need to come from the state and local health department, because of course they're the folks who will know what you're regional situation is. But I think it's a really - a potentially very good idea to discuss with your state or local -- and/or local -- health department.

(Gary McKay): Yeah, it is a big obstacle. We've asked that question and we've got a response of no right now, but it's very - I think it's very important information for hospitals to have at least the number of suspected cases.

Man: Yeah, I think that is a very good point that you are raising.

Man: Okay, I appreciate your time.

Man: Thanks Arjun.

Coordinator: thank you and our next question is from (Shay Simmons).

(Shay Simmons): Yes this is (Shay Simmons) from the McLean County Health Department in Illinois. My question is Dr. Lurie referred to making patient referrals assuming we are monitoring patient new contacts despite the fever. And the statement was made to refer them to an emergency department that is known to be trained and ready to receive an Ebola patient. Both of our hospitals in this country have stated that they are ready, but is there some other set of criteria that we should be using? I assume that our hospitals are ready, they have told us that they are ready, but I was just puzzled by Dr. Lurie's use of the word known.

Man: You know I think the - what - I can't speak for her and apologize that she had to take it off the call. I think what she was referring to is this you know strategy that is in place where the health departments are working with hospitals in their areas to determine where people would go so that you know the emergency department where a person might go, EMS, the health department and so everybody is you know kind of on the same page you know if that phone call comes. Or when someone calls in and they do have a fever, there is a common understanding of where the person would be sent for evaluation. I believe that is what she was referring to and that could be (unintelligible).

Woman: (Unintelligible) could be from after. I could also let you know too that as you mentioned we are developing a system that encompasses everything from kind of facilities that would assess patients as well as those that would definitively care for them. Obviously, needing a much fewer number of those that would do that definitive treatment and there is guidance in development that will be cleared in the very near future and sent out, and we have been working with (ASTO) and other partners as well to kind of vet some of that information. So you can certainly be expecting that certainly in the coming weeks.

(Shay Simmons): For those of us in rural areas, in agricultural counties for example, we do have two hospitals in Illinois that I believe have been designated as Ebola treatment centers. But if we get a call and then we would then have arrange to send a patient to Chicago, that's 120 miles away. So that's why I was questioning the known. We are not in the position to drive someone all the way to Chicago if they have - if they are monitoring them and they become febrile or demonstrate any of the symptoms. That was just why I was asking.

Gregg Margolis: That's a great point. This is Gregg Margolis. Maybe I can take that issue. We readily recognize that in order to have a regionalized approach to this serious

infectious disease sort of management, it will definitely involve pre-hospital and inter facility transportation that is - in some cases could be complicated.

Clearly, there are some parts of the country, regions, and localities that have emergency medical services and medical transportation resources that would be able to do these sorts of transportations easily. Maybe not easily, but at least they are able to do it safely. And but we also recognize that there might be parts of the country that would be very challenged to do this and you mentioned rural America with maybe some of those communities.

So we at the end of last month released a request for information to the public to see if there might be a possibility of entering into a contract with a national ambulance provider that might be able to assure a backup system should a community need one, and we are currently exploring the feasibility of that and hope to have more information soon.

(Shay Simmons): And I am not going to assume that simply because we are an agricultural county that we do not - that we will never see an Ebola patient because we do happen to have a handful of residents in this county from West Africa.

Gregg Margolis: I think that is a very important point to make and just having some knowledge of where some of the PUIs have cropped up, they - while many of them follow a somewhat predictable pattern, there is always an outlier every once in a while. So that is a good reminder that really everybody in the health care system really wherever you are needs to remain vigilant.

Coordinator: Thank you. Our next question is from Dr. (Peter Anderson).

(Peter Anderson): Thank you, I am from Orange County, California. We all know that we are going to have to use protective equipment in the event that the patient comes

in from West Africa and has vomiting along with a fever. However, the likely scenario is for the patient stating that they are from West Africa but they just don't feel well. What is your recommendation as far as protective equipment there? They have none of the other symptoms, they look well.

Arjun Srinivasan: Yeah, this is Arjun and administrator do you want to comment on that?

Man: Yeah if they are not I think bleeding, vomiting, copious diarrhea, then we would recommend the PPE for clinically stable patients. That would be facial and surgical facemask, impermeable gown, and two pairs of gloves. But now if that patient started vomiting, it's different.

(Peter Anderson): Are you saying with vomiting you would recommend the (papper).

Man: Correct, we would recommend the PPE. Well it is the PPE for hospitalized patients of which the (papper) is a component or the...

Arjun Srinivasan: Or the 99 respirator. Basically, if there are secretions bleeding, blood, vomit, diarrhea, then we do recommend the respiratory protection, the higher level of protection. And so, that would be as the (administrator) is mentioning the hospitalized guidance. But if those symptoms are absent, and like you are point out, I think that is more likely to be the case now where we are referring these patients in sooner, then you can use this other recommendation for protective equipment that I think it is a lot easier to obtain and it is PPE that health care workers are a lot more familiar with and comfortable with because it is stuff that we do actually use in the routine care of patients.

(Peter Anderson): I have a second question. The testing that is being done now, there was a statement by I think the CDC a number of weeks ago that you cannot have a fully negative test until three days after the symptoms start. In other words,

your initial test is negative, then you have to wait another three days to get a second negative test before you are sure that the patient that is vomiting and having diarrhea is negative. Is that still the situation? Others have told me that this test is fairly accurate and it has been accurate on all patients with their initial symptoms. They've ended up being positive on that first test.

Arjun Srinivasan: Yes, that's a really good point in (Merit)'s clarification. So the test that is being done is very, very accurate, very sensitive, very specific. It is a real time preliminary chain reaction, our PPCR for Ebola virus. The issue that is being raised there is that (viremia) to become detectable takes about three days from symptom onset. And so if you are seeing a patient at the moment or say within 24 hours of symptom onset, then a repeat test - and they test negative. It is possible that they have (viremia) that is just below the level of detection of the assay.

And so you would need to retest that person three or more days after symptom onset had occurred. But if you had a patient that came in - you know most of the patients who manifest these gastrointestinal symptoms - they are several days into onset. You know the median onset of the gastrointestinal symptoms is about five days from onset, so when those folks walk in, they are very likely if they have Ebola, very likely to have detectable levels of virus in their blood. So that's the issue there. It is the need to retest people who are within the early window where the (viremia) might not be yet at the level of detection. Does that make sense?

(Peter Anderson): Yeah I guess so. So what you are saying is that there is no way we can rule out Ebola until we wait three days.

Arjun Srinivasan: If you have a patient who you were evaluating whose symptom onset is less than three days then yes you would need to repeat that test three or more days from symptom onset. That is correct.

(Peter Anderson): Okay thank you.

Coordinator: Thank you. Our next question is from Dr. (Andrew Byrne).

(Andrew Byrne): Thank you very much. I am from Florida. The question that I have is it has been referred in the media that the goal is to have 50 centers with - or Ebola qualified or certified in some way with the goal of having at least one for every state. I've looked at your site and do not see the listing of these 50 centers. Also, in terms of it has been stated that it is centralized through different health departments of who can actually do the Ebola testing. Is there a place I can go to that identifies who is certified to do the Ebola testing, where they are within each state, or do they all go to the CDC? And where the Ebola certified centers are listed.

Arjun Srinivasan: This is Arjun. I can comment on the testing issue and maybe Dr. Margolis can comment on your other question. In terms of testing, that can all be directed through your state health department laboratory. The Ebola test is available in some state labs. It is available throughout the laboratory response network laboratories and available here at CDC. And so, the state health department can help you coordinate where you would be sending a sample for testing for Ebola. And Dr. Margolis do you want to address the other issue about designated hospitals.

Gregg Margolis: Sure, so you referenced the proposal that the president has sent to congress for additional funding for Ebola and part of that proposal that has not been voted on by congress yet is to stand up Ebola treatment centers or serious infectious

disease treatment centers in roughly every state. Obviously that has to work its way through congress at this point and we are certainly hopeful, but there has been no action on that at this point.

(Andrew Byrne): Thank you and do you have - just a follow up. On the statement with the health departments, is there a written procedure and method by which a hospital can get their samples to the health departments with suspected Ebola blood? I imagine that certain carriers or couriers are not going to be too happy about transporting this. Is there a process in place for guidance of how to get a sample from your facility to the health department?

Arjun Srinivasan: This is Arjun. Yes, there is a specific guidance document on the CDC Web site that addresses just that issue. It talks about all of the details, how you would package it, how you would transport it, who you would call, where it would need to go, and so that is on the CDC Web site, cdc.gov/ebola. And if you click on the link for health care professionals, all of that information is described there.

(Andrew Byrne): Thank you.

Coordinator: Thank you and sir I am showing no further questions at this time.

Man: Okay, then we will thank everybody one more time. And to our colleagues at the CDC thanks so very much for doing this with us. Gregg and Melissa thanks so much for doing this with us and to all of you who attended the call, we appreciate all that you are doing to get the health system ready. If there is nothing else operator, I think we can end the call. Thanks everyone and have a great weekend.

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

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