ADMINISTRATION, KANSAS DEPARTMENT OF

Moderator: Mindee Reece
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11:00 a.m. ET

Operator: Good morning. My name is (Brandy) and I will be your conference operator today. At this time, I would like to welcome everyone to the Statewide Ebola Update Conference Call.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

I'd like to turn the call over to Ms. Mindee Reece. You may begin your conference.

Mindee Reece: Good morning, everyone. Thanks for joining us on somewhat short notice. We'll have two speakers this morning: Dr. Robert Moser, KDHE Secretary and State Health Officer, and Charlie Hunt, State Epidemiologist.

Robert Moser: Good morning. I (thank) everybody taking time out of their busy schedules to be on the call today, and I think it's going to be good call; we have a lot of information to share with you. We're planning on leaving plenty of time for questions at the end.

I also want to let you know that our plans are to hold a Weekly Population Health Call for at least the next few weeks as we continue to work through the Kansas Ebola Preparedness and Response Plan guidelines. We are working with feedback from our many stakeholders as we continue to adjust as needed

with many of our plans based on lessons learned from not only the experiences with many organizations in dealing with the Ebola outbreak in West Africa but also in Dallas, at Emory, and in Kansas as well.

As you know, as I will tell, obviously the Governor has been kept up-to-date on the activities and by me and others and has directed a more proactive approach to helping reduce the risk to Kansans and all medical providers from Ebola. And so with that, we have some updates in our guidelines that Mr. Hunt will be reviewing with you this morning.

So, with that, I'm going to turn it over to Charlie so he can go through this plan and response.

Charlie Hunt: OK. Thank you, Dr. Moser, and good morning, everyone. I'd like to briefly provide a situational update on what's going on nationally, as well as some of the preparedness and response efforts in Kansas. Briefly, I will go over the case definition for Ebola virus disease and review how we would conduct case management for a suspected case. Then we want to offer a lot of time for questions and discussions at the end.

So, again, just very briefly, I'm sure many of you are aware there are two ongoing outbreaks of Ebola virus disease in Africa. One is occurring in West Africa that started back in December of last year and was reported publicly in March of this year. These numbers are changing very rapidly but as of right now, there are nearly 9,000 cases between the three countries of Guinea, Liberia and Sierra Leone, and nearly 4,500 died.

There were also some cases in West African Nation of Nigeria; however, it's been more than three weeks since the last case occurred there and anyone who was in Nigeria on or after September 30th is now no longer considered to be at risk of Ebola.

There's a separate outbreak occurring in a Democratic Republic of Congo that started in August 2014, and so far there have been 70 cases and 43 deaths. That outbreak appears to be slowing down. The case counts have not gone up over the last several days at least, but we are still continuing to monitor the

situation there, and as for now, that is still considered an affected country and anyone who traveled in the Democratic Republic of Congo needs to be considered as being at risk for Ebola.

There's a lot of information about Ebola virus disease available via links on our Web site. We have a new landing page, and if you go that page, you can get a lot of more detailed information. So, I'm not going to spend a lot of time going into the background of Ebola virus disease right now.

I think it's important to note that Ebola is transmitted through direct contact, through bodily fluids in a person who is sick with or has died from Ebola, through object-contaminated virus such as needles and medical equipment or through infected animals. The general thinking is how it gets into a human population is from the animal reservoir.

Ebola is not transmitted through the air. It's not a respiratory disease. It is transmitted through direct contact to bodily fluids. The incubation period is typically eight to 10 days but can range from two to 21 days. The symptoms include fever, severe headache, muscle pain and weakness, diarrhea, vomiting, abdominal pain and unexplained bleeding.

Treatment for Ebola virus disease is really just supportive care; balancing fluid and electrolytes, maintaining oxygen status and blood pressure, and treating for any complicating infection.

The primary concern for those for us in Kansas and for the other states is from exposed travelers returning from affected countries. Estimates are that approximately 150 persons per day arrived in U.S. from the African nations of Guinea, Liberia and Sierra Leone.

As you're probably aware, any passengers departing from those three countries are being screened as they exit the countries. The CDC announced that entry screening has been implemented at the five airports in the U.S. that are receiving 94 percent of persons traveling from West African Nations. This assessment includes health history questionnaire, information about potential

exposures and measurement of temperature. If there are concerns then that person is evaluated further.

Of course, the first case diagnosed in U.S. occurred in a traveler from Liberia that was reported on September 30th. This person was asymptomatic during his travels and, again, arrived in Dallas, and as you're probably aware, that person died on October 8. We've now seen two health care workers who cared for this patient become infected. The first one was announced on October 12th and the second one was announced just yesterday. So, again, this heightens the concern for us.

I think it's important to note that the preparedness and response plan we have developed focuses on conducting risk assessment among persons who have been traveling in one of the affected countries and are coming back into Kansas. Everyone who has been in one of the affected (countries) should have a risk assessment done. This risk assessment can be conducted by the Local Health Department or by KDHE. It could be conducted by health care providers such as infection prevention nurse in the hospital, for example, or it can be conducted by another organization in consultation with the local health officer or KDHE.

The risk assessment is available in draft form within the preparedness plan we issued back in August. Of course, it's available in the revised draft that we'll be posting soon.

The risk assessment focuses on potential exposures and any potential symptoms and, again, it's important to note that a symptom of Ebola virus is fever and that would be either subjective history of fever or fever that's measured.

The CDC right now in the case definition is defining measured fever as 101.5 degrees Fahrenheit or 38.6 degrees Celsius. However, in evaluating the persons coming back, those criteria are being lowered…..with the events of the last couple of days with the second nurse who's been infected, I think they are probably going to lower that even more or at least put more emphasis on the subjective history of fever.

Other symptoms include severe headache, muscle pain, vomiting, diarrhea, abdominal pain or unexplained hemorrhage. And again, it's very important to keep in mind the epidemiological risk factors of travel within the past 21 days in one of the affected countries before the onset of symptoms. If a newly symptomatic person was in one of the affected countries more than 21 days ago, they would not be considered at risk for Ebola.

Once a person is identified as a suspected case, of course, it requires immediate notification to KDHE. We have in our regulation, there's a kind of a catch-all requirement for diseases that are unusual, in incidence or behavior. And so Ebola virus disease certainly falls into that. But we've determined that it must be reported immediately by telephone to us at our epidemiology hotline at 877-427-7317 and when – once we get a report – we will work very closely with the health care provider of the hospital and the Local Health Department to ensure that the case is managed appropriately.

A person who is suspected of having Ebola virus disease needs to be immediately isolated in a private room with a bathroom. Any staff who are working with that patient need to use standard contact and droplet precautions, which include an impermeable gown, gloves, mask, eye protection such as face mask or goggles, and, if there are copious amounts of blood or other bodily fluids, shoe covers and leg covers should also be considered.

Any person that has been determined to be at least of some risk of exposure to Ebola virus through their travel history or to a case here in Kansas will be required to undergo active monitoring. This includes monitoring of temperature and other symptoms twice a day and follow up by the Local Health Department via telephone or other communication means. The monitoring would not be conducted in person because we don't want to risk additional exposure.

In addition, we are, right now, considering imposing movement restrictions on persons who've been exposed to Ebola virus. That would entail remaining at home for a period of 21 days and not having visitors during that time. Any movement outside the home would need to be considered on a case-by-case

basis, with a decision to approve or disapprove by either KDHE or the local health officer in advance.

As a patient is presenting to a health care facility or hospital you should contact KDHE. This will allow us to go over the basic information, the clinical history and the travel history. We will then determine if it's appropriate to then contact CDC for consultation regarding whether the criteria for laboratory testing is met. It's important to note that CDC will not test on demand.

We have to very carefully assess the patient's clinical history, travel history and exposure history and include that in our discussions with CDC before they would agree to test. Also, prior to that, KDHE has to approve the testing. So, the health care providers in hospitals can contact CDC directly without going through us, however, CDC will not test without KDHE's concurrence.

I'd like to take this time now to open it up for questions.

Operator: At this time, if you'd like to ask a question, press star and the number one on your telephone keypad. We will pause for a moment to compile the Q&A roster.

Operator: And we have a question from the line of (Sunshine Hicks).

(Sunshine Hicks): Hi. We are just curious, we're a small critical access hospital and if something presents to our front door, how are we – I mean, we're putting up signs let's say, if you have a fever, you need to put on a mask and such, but how do we protect our frontline staff?

Robert Moser: Yes, this is Dr. Moser. Since it is direct contact, there's a number of ways to protect frontline staff. You could consider if your facility has a higher likelihood of having folks who may be traveling through and stopping off. So in other words, along I-70 or I-35 there are many communities where visitors might somehow arrive. So, since it's mostly direct contact, I would say, you know, at least wear gloves.

If you're physically at least three feet away from somebody affected, since this doesn't transmit through the air, you should be safe. And so it allows you an opportunity at least to do the risk assessment and then determine management from there.

If a person has a relevant travel history or exposure to an Ebola patient, obviously you need to immediately isolate that patient into a private room with its own private bathroom and secure how the people enter and exit. People should not enter that room without wearing the appropriate personal protective equipment. With that personal protective equipment, basically, you know, no skin exposed would be highly recommended and impermeable.

Operator: And we have a question from the line of (Susan Cooper).

(Susan Cooper): Yes, I have a question from the previous call and then, again, with this one, if you have a dedicated team of health care workers for taking care of Ebola patients, then they are in the high-risk exposure category, previously so that they are to be in one location quarantined for 21 days. Does that include that Ebola team as well?

Charlie Hunt: Right now, the draft plan that we have is that anyone caring for the patient by definition would have at least some risk of exposure, so they would be put into that category. What we are proposing for – at least for discussion – is that an identified dedicated patient care team would care only for the one person – the members of that team would be subject to the same monitoring requirements as someone who is exposed in one of the other affected countries. Their movement would be restricted so they would be required to stay at home and not have visitors. And again, the only exception would be obviously that they would need to continue caring for that patient as part of the team.

(Susan Hicks): So, what you're saying is that their restriction is only between the hospital and home; it's not that the hospital has to house them during that three-week period?

Charlie Hunt: That's correct.

(Susan Hicks): Thank you.

Charlie Hunt: OK.

Operator: And we have a question from (Krista Hessler).

(Krista Hessler): Hey, thank you very much. I just was wondering if there's any consideration in establishing set hospitals to manage the care of the suspected Ebola patient. Again, I am from a small rural hospital. I have four full-time nursing staff. This would overwhelm us. This plan would not work ideal in our hospital. Actually, it won't – it wouldn't work at all.

So, I'm just hoping you guys will consider that and Kansas could be the leader in managing this better.

Robert Moser: This is Dr. Moser. Certainly appreciate your comment and understand the resource restrictions for critical access hospitals, however, a couple of things on that. One, if someone would happen to present to your facility that meets the case definition, the time frame of basically determining whether or not they are indeed positive for Ebola requires that you have capability to at least isolate that patient to prevent further contact. That would consider the scenario of, if you thought that they were high risk based on the history and you wanted to ship them out to the next higher facility.

We don't want to continue to expose additional patients to someone who would be considered high risk and symptomatic. So, once they present, it really becomes your responsibility to control that person from exposing additional folks. I realized what that puts small systems under, but you need to at least have that capability for a day or two until that test is confirmed. Then arrangements can be made for appropriate transfer of the patient.

I will tell you that for the last couple of weeks we've been working on a number of options including discussions with the biocontainment unit in Nebraska about accepting patients from Kansas. I think it makes more sense that these patients are taken care of at the appropriate level by centers that are more likely to have the resources available as far as personnel that are trained

and more comfortable in managing these complex patients under complex settings.

However, at this point in time, the Nebraska Biocontainment Unit is not necessarily willing to just open the doors to any and all transfers. This would be something we would work to accomplish once you contact KDHE that you have suspect Ebola patient.

We will then work through determining if their case history fits the definition and making arrangements with the CDC for the testing and confirmation. During that same time frame, we would probably also contact the biocontainment transfer team that we've identified, which will have the proper equipment, to put them on standby for possible patient transfer.

We would then also probably reach out to the Nebraska Biocontainment Unit to consider the possibility of the transfer and/or we would also be visiting with some our regional larger medical centers as to their willingness to take such a patient.

I would recommend for the critical access hospitals to visit with your usual referral pattern hospitals as to what their plans are should they get a call from one of their usual referring critical access hospitals so that we kind of know upfront ahead of time which facilities are prepared and are continued to prepare to mange Ebola cases and what the needs for transfer out-of-state would be in the long run.

So, we are working on that. We are also even exploring the possibility of a facility that would be set up to be a dedicated Ebola Treatment Center in Kansas. Obviously, that's a lot of work. We still need to determine the logistic to go with that such as the equipment, the location, the staffing and such.

So, we are continuing to work on that and I appreciate the idea. Many other providers across the country are indeed asking the same question; if we manage our trauma system by identifying what the needs are of the patient

and moving them to that appropriate level of care, why aren't we doing that with an infectious disease such as this?

So, I think you'll be hearing more about this from the national level as well, but we will also continue working on that. I also wanted to mention that when the call comes in to KDHE, we are developing an Ebola Response Team, if you would; I prefer to really call it a Bio-Response Team because it may be for other reasons than Ebola. We're going to, through our K-SERV system; ask for folks that have signed up to respond to disasters within the State of Kansas, to consider the possibility of serving on this Bio-Response Team. This could be a team to assist a facility where they are understaffed or they have staff that by number desire not to treat or be exposed to such patients. This team might be able to supplant or reinforce the needs at the local level as well. So, those are the many activities we're working on here at KDHE.

(Krista Hessler): Oh, thank you. That comforts me to know that you're definitely thinking about it.

Operator: And we have a question from (Nancy Johnson).

(Nancy Johnsons): I was wondering if you would please address if a patient would be transferred to a biocontainment unit and the original facility that they presented at, what your protocols for decontamination are.

Charlie Hunt: The draft plan that we have does address the decontamination recommendations. So once again, any non-porous surface that can be cleaned by an EPA-registered disinfectant for a non-enveloped virus can be used to disinfect for Ebola. Any medical waste that's generated would need to be autoclaved on site or handled and managed as hazardous waste. And again, that is detailed in our draft plan.

Operator: And we have a question from (Douglas Rose).

Mindee Reece: (Brandy), can you – before (Douglas) speaks, again provide the instructions for how to ask a question please.

Operator: Again, if you'd like to ask a question, press star and the number one on your telephone keypad.

(Douglas Rose): Hi. This is (Douglas Rose) from (Marysville). I had a couple of questions for the medical epidemiologist. She wanted to confirm that there's no plan to have Ebola testing done through KDHE directly. Obviously, the approval would come from KDHE but she is asking about technically performing an actual test and the second question about EMS doing a travel history screening – where we are on that and what is the requirements that are being put out regarding that?

Charlie Hunt: On the first question, we are not planning at this time to develop the capability for laboratory testing in house.

Robert Moser: Actually, since last night, the CDC has basically started asking other state labs as to their willingness to look at being another one of the regional testing sites; and we have notified them that the Kansas Public Health Environment Lab is interested in taking on that capability.

Now, that will take, a couple of things, one, the CDC has to approve it; the second is that we have to basically set up the process and validate it, and then get the final approval to move forward with actually performing the test. That would help somewhat in the turnaround time for the initial test, but the actual confirmation final test still has to come from the CDC.

(Douglas Rose): OK.

Charlie Hunt: And then your second question was about EMS staff doing a travel history screening, right?

Charlie Hunt: Well, I would suggest that it would be appropriate for EMS to screen for the travel history if they are the first health system contact with a patient. And then if that patient needs to be transferred to hospital, of course, then EMS should call ahead and advise the hospital that they're bringing in a patient with pertinent travel history and symptoms and that they should be managed as a potential Ebola patient.

Robert Moser: And obviously, if a patient has a relevant travel history and is symptomatic, you should immediately put on your personal protective equipment at the appropriate level. Ideally, any surface that's porous that this patient has been placed on becomes impossible basically to decontaminate. It would have to be sterilized or destroyed.

So, you may want to walk through the scenario of what would you do if you walk into an apartment of somebody who is symptomatic. You would put on the PPE and get prepared for transport. What would you need to do within your unit to limit the contamination to avoid having units out of service for extended periods of time?

Operator: And your next question from the line of (Tee Walton).

(Tee Walton): Thank you. My name is (Tee Walton); I'm the sheriff of Harvey County. Let's consider questions regarding some of the law that happens here. You mentioned that if a person refuses to go into isolation or quarantine and they would be forced into that, how do we do that?

Charlie Hunt: That would be conducted in consultation with the local health officer. Kansas statutes do provide for authority for the local health officer to utilize law enforcement to enforce quarantine if necessary.

You know, again, I guess on an extreme case it would first be the law enforcement outside somebody's door. Hopefully, it wouldn't come to that.

Robert Moser: What we're talking about are isolation requirements and, as long as a patient would comply with the daily temperature monitoring and approval for movement outside of the home, as long as they're compliant with that, we wouldn't feel the need to go through the quarantine order.

(Tee Walton): Second part to that question, I receive different court documents that we may have to serve on people that require them to stay in isolation and quarantine. Again, with my deputy going to the door handing people these papers, I have somewhat of a problem with the deputy just going up there who now could become infected with whatever that person has.

Charlie Hunt: Again, Ebola is transmitted by direct contact and so if your deputy is merely handing papers through a doorway that would present a very low a risk for infection.

Robert Moser: And the patient would need to be symptomatic. In other words, you really don't develop symptoms unless you have enough virus in your system to create that immune response. So, up until that point in time, again, the likelihood of just the casual contact, a three-foot separation while you're carrying out a conversation, the likelihood of exposure and contracting Ebola is very remote.

They could certainly put on latex gloves. They can wear an N95 mask just for their comfort to add a little bit extra barrier precaution, but they'd also need to realize that just because they have that on, if this would happen to be an asymptomatic patient and they touched their hand or whatnot with a glove, they still need to know how to take those gloves off appropriately then wash their hands with soap and water.

(Tee Walton): Thank you.

Operator: And the next question comes from the line of (Kelly Cole).

(Kelly Cole): Hello. Our questions are if we are facility that does not have the autoclave or the incinerator, what are we to do in the meantime to handle waste and also what do we do if we don't have the supplies or the capabilities for the testing? How will that be handled?

Charlie Hunt: Very briefly on the handling medical waste, again, it needs to be handled as hazardous waste and there are specific requirements in terms of storage and shipment of those materials, that is detailed in the draft version of our plan which is now posted on our Web site. But there are very stringent requirements for how that is managed.

And your second question, again, was you don't feel you have the supplies to do the isolation or the testing?

(Kelly Cole): For testing.

Charlie Hunt: OK. I would say you get in touch with our laboratory staff and, again, just to reiterate, pointed out by Dr. Moser that is that any hospital needs to be prepared at least for that initial evaluation and management of a suspected patient for some period of time, which would include collection and management of an appropriate specimen for testing. So, please contact us and our laboratory and we'll help you get the materials that you need.

(Kelly Cole): Thank you.

Operator: And our next question comes from the line of (Stephanie Swirsky).

(Stevie Swirchuski): Yes. This is (Stevie Swirchuski) and what is the infectious dose?

Robert Moser: I don't know the exact number, but it's low.

(Stevie Swirchuski): I thought somewhere I had read one and I thought wow and that's why just wanted to see if we knew.

Robert Moser: I don't know the exact number on that but I think if we want to talk about how contagious is this if you have a contact case of Ebola the RO is two, for HIV patients the contact infectious rate is like 4, for measles it's 18. So, that just kind of shows that we've got a lot of other agents out there that are far more infectious or contagious if you would than what Ebola is and so, again, it's kind of coming back and looking at the signs and just using appropriate level of cautions and three-foot physical separation is enough if you're not having direct contact with anybody that may be shedding the virus.

But that's, because of the incidence down in Dallas, why we're recommending that the PPE should cover all skin if you're going to be involved with direct patient care.

(Stevie Swirchuski): Thank you.

Operator: And the next question comes from the line of (Michelle Williams).

(Michelle Williams): Yes, I think you answered ours, which was on hazardous waste where a Critical Access Hospital and where you said in fact that they will not accept

class A hazardous waste. We do not have an autoclave or incinerator but he said I think that there is online a place we can go to find that information and we were unaware of that.

Charlie Hunt: OK. Thank you.

Operator: And the next question comes from the line of (LaDonna Reinhardt).

(LaDonna Reinhardt): Hi. This is (LaDonna Reinhardt) from (Lincoln) County. I have two questions. One is the isolation gowns that we have is a light fluid contact isolation covered gown. Is that considered impermeable? Or is there another gown we should be finding?

Robert Moser: Yes, if you look at a lot of the care providers that utilizing the World Health Organization UN Guidance, they are putting basically a waterproof apron over the front. A lot of the materials in some of your PPE do shed water but if you're leaning up against the moist material it will begin to soak through.

So, again, I think you just want to be certain that it's water impermeable and so therefore if you need to put a waterproof apron over the front of that, add that extra layer protection that certainly the wise thing to do.

(LaDonna Reinhardt): The second question that came out from our discussion is that legally it's basically the local health officer and CDC really doesn't have any legal standing. Correct?

Robert Moser: The local health officer has a lot of authority.

(LaDonna Reinhardt): Right. But CDC has none, legally, correct?

Charlie Hunt: Well, this gets a little complicated but CDC is essentially invoking the Commerce Clause of the Constitution to deal with Ebola right now and so I think that's how they are instituting a lot of their actions.

(LaDonna Reinhardt): OK. So, they're not giving recommendations. They're actually issuing things that are required.

Robert Moser: Guidelines would be the way to look at that and as you may have heard, we are also looking at if a call comes in to mobilize a team and it's really a technical assistance team, it's not to come in and takeover anything. It's just to be there to help provide information and answer questions and help observe that everything is being done appropriately and maybe even identifying resource needs where we can help provide that.

CDC yesterday announced that, you know, they're going to be also mobilizing for positive Ebola patients, a response team as well and they've also pointed out that, again, it's just there to really precise – provide for oversight and monitoring. It's not really to step in and takeover.

(LaDonna Reinhardt): OK. Thank you.

Operator: And our next question comes from the line of Harper County.

(Tom): Yes. We have actually two questions. (Tom), I'm the emergency manager, I'm with my health director also. One is the risk assessment for individuals that you guys put out for health departments to use. Are we supposed to use that still in draft status or do you guys want to take the draft status off that?

Charlie Hunt: Our plan is to get this finalized and initiated as an official version with the caveat that it's subject to change and just like just yesterday, CDC distributed a contact form to be used for risk assessments as well. And so we're going to be reviewing that document and comparing it to ours to identify the differences. Absolutely, we may adapt the one that's CDC is using. But for now, you can go ahead and use that if a situation occurs. That document has not changed much since the last version of plan that we published on the 9th.

Charlie Hunt: Good question.

(Tom): Our second question, is there a press release available for small health departments to provide an update and basic steps to protect themselves? Is that coming from the KDHE?

Charlie Hunt: We will work with our Office of Communications to go ahead and basically prepare kind of a press release template with the basics to distribute, so that

everyone can kind of be approaching this from the same direction, yes. We'll get that posted as well here yet today.

(Tom): Thank you very much.

Operator: Our next question comes from the line of (Brenda Davis).

(Brenda Davis): I also have two questions. The first is we are an outpatient facility and when people call in to request an appointment for flu-like symptoms we will go ahead and do the screening. If that is positive, of course our first step would be to notify KDHE, but does our responsibility end there?

Robert Moser: That's a great question and what I would recommend is obviously I think you want to make two calls. One would be to notify KDHE, made to the Epi hotline. The other would be to have readily available by your phones the local ER phone number, so that you could one, recommend that they go immediately to the closest emergency room and identify whether that's been called in to give them notice that such a patient would be arriving.

(Brenda Davis): Right and that was our plan but what if that person doesn't go? I mean we don't know that but the state will be following up on that, correct?

Robert Moser: Right. We certainly would want you to get all personal contact information for the person.

(Brenda Davis): Right.

Robert Moser: That will be needed so we can follow-up.

(Brenda Davis): Sure.

Robert Moser: Yes, we would take that from there and we would probably ask as well which hospital you referred them to.

(Brenda Davis): Right.

Robert Moser: So, we can either reach out to them as well or if we don't get a call obviously from them in a short period of time, we would be contacting the patient to

identify where they're at. That definitely does post a little bit of problem but if you're dealing with a person that's not standing in front of you, that's probably the best approach we can take at this time.

(Brenda Davis): OK and the second question is on having a healthcare worker-dedicated team. If we have someone come in, it's going to be for a very short stay. They're going to be here for maybe an hour or two hours and they would be transferred out. Would that team have to change every time because they would not be seeing the same patient? It may real quickly deplete our staff.

Robert Moser: Another great question and we're sitting down and visiting the staff and the team as to how you would manage that but indeed if you have a high-risk patient meets the case definition as symptomatic, you essentially have to assume that patient poses that risk to you and your staff and your facility. So, you, by all means, would want to immediately isolate them into a room with its bathroom and depending on what support that patient needs, that someone would likely need to be in contact for that patient, so they would need to get immediately garbed up in their PPE in order to care for that until such time transfer could be made.

The transfer obviously would involve a number of options that are not necessarily always applicable to the clinic setting, although there have been some cases of where that did apply depending on how your governance is organized. It could be a question you also need to discuss as to whether you put him back in the private car and send him directly to an emergency room or whether you call EMS but all of those possible contacts from that point forward maybe obviously notified of the high-risk scenario and to take appropriate personal protective equipment and barrier precautions.

(Brenda Davis): Right and I understand that on the patient part, what I'm talking about is the healthcare team providing the care here. Your recommendation is you have a dedicated team for one patient. Well, that patient is only going to be here a short time.

Robert Moser: Yes, we'll have to discuss this a little bit further but essentially the way we are looking at it at this point in time, even a person in PPE will be at risk for exposure.

(Brenda Davis): Right.

Robert Moser: Anyone within direct contact with this patient should probably basically be removed from your care team. Once that patient is transferred out, the care staff should sent home to be isolated until you find out whether or not this is a positive Ebola patient or not. If this was a positive Ebola patient, then they basically are on that monitored isolation for 21 days.

(Brenda Davis): Twenty one days, yes, OK, that answers my questions. Thank you.

Operator: And your next question comes from the line of (Harley Madison).

(Harley Madison): Yes we have two questions. One is about our concern with our refugees and our immigrants coming over from Somalia. What is the concern there that we should be with them?

Robert Moser: None.

Charlie Hunt: Yes, it's not one of the affected countries, so that's not a concern.

(Harley Madison): OK and then the other question we have is you guys were talking about its direct contact but then before, you talked about being in droplet isolation, can you explain that a little more to us?

Charlie Hunt: You know since the standard contract in droplet precautions in the healthcare setting are the recommended precautions for preventing transmission. When considering potential exposures though, the close contact or more casual contact is considered as a potential risk. And so anybody that's have that potential risk of exposure needs to be monitored and for 21 days and put in appropriate, again, restricted movement.

(Harley Madison): OK and what's the risk, what's – like say somebody had it in the risk with sneezing?

Charlie Hunt: The risk of transmission from sneezing is much less than it would be from exposure to blood for example. The level of virus in saliva is just not as high as it is in blood.

(Harley Madison): OK, thank you so much.

Charlie Hunt: Yes.

Operator: And your next question from the line of (Jean Marie).

Mindee Reece: (Jean Marie), are you there?

Operator: She disconnected.

Mindee Reece: OK.

Operator: We do have one from (Liz Thicker).

Mindee Reece: (Liz), are you there?

(Mavis Perkins): Hello? Hello.

Charlie Hunt: Hello.

(Mavis Perkins): This is (Mavis Perkins) from (Kansas) County. I'm a – I've been getting calls from the Safety Net Clinic and some EMS; they're requesting a special training. Does the state going to have training for them in particular?

Charlie Hunt: Yes, I'm glad you brought that up.

(Mavis Perkins): They're talking about donning and undonning and cleaning after decontaminating.

Charlie Hunt: Thank you for bringing that up and we actually have Joey Scaletta, who's our Healthcare-Associated Infections Program Director, has developed a PowerPoint presentation about that we will make that available and then we'll discuss some potential options for doing that presentation. There are also videos available on the CDC Web site, the Ebola page that can be utilized as resources.

Robert Moser: As we identify the bio-response team through K-SERV that we were talking about earlier, the plans are that we would basically make certain that team goes through donning, doffing, PPE training, decontamination of the patient care-type training. And with the hopes that essentially, depending on the numbers of folks that would volunteer for such a bio response team, the team members could serve as local trainers to continue to multiply those efforts across the state.

Operator: And your next question comes from the line of (Catherine Serono).

(Catherine Serono): Thank you for taking my question but I think it's been answered. I was going to ask about Nebraska accepting patients from Kansas and you answered that earlier. So, thank you very much and this has been very interesting.

Robert Moser: Yes and thanks for being on the program today. I do want to add that one of the requirements that will have to be met for any transferred in Nebraska, as I mentioned, we would start reaching out.

For Nebraska, we have to get basically approval from their state health officer as well as their medical director for the bio containment unit before we would then probably be able to make that transfer arrangement.

During that time frame, they of course would probably want to wait to decide to utilize and activate their resources only for a positive Ebola patient. That's the reason that our Kansas hospitals need to be able to probably at least looking to manage one of these patients for at least two to three days.

(Catherine Serono): Well, thank you very much.

Operator: And your next question comes from the line of (Gay Hall).

Male: That's (Gay Hall).

John Paul Jones: This is John Paul Jones, Chief at Kansas City Kansas Fire Department. We have the largest fire-based EMS system in the State of Kansas, transporting about 18,000 patients a year.

Some of the concerns I have is in, you know, I mean one of these things that we had to come to grips with is we have to think on our feet, develop our own protocols here because things are moving pretty rapidly. But my question would – it comes from two things, one I will call phase 1 and the other phase 2.

Phase 1, I would say, we have to deal with the issue of chain of custody of this disease, in that, you know, I have to answer multiple questions with our personnel and I have to have the answers before we'll get that call to go transport somebody who is suspected based on the criteria and that – this I would consider phase 1.

And so that when we run these calls and we take the necessary precautions, I think the – one thing that needs to happen maybe is do we get out of standardized protocol for the specific-types of PPE, how it's worn and how we – and specific protocol in decontamination procedures associated with running these types of cause.

Because, I think those are the unanswered questions as are we doing it the right way? Is there a standard, you know, that's out there that says this is specifically what we are to do in regard to this disease? So, it's kind of evidence-based standardization based on this chain of custody and when our people transport, let's say somebody has a fever, they'd been to West Africa, we go to their home; we transport them to the hospital.

And so what do we do now, what are we going to do with the ambulance? We know what to do: we're going to decontaminate the ambulance. What do we do with hazardous waste? There's a question that comes out of that specifically. And then what do we do with our personnel? I mean you have a, you know, let's say it's a two-day minimum incubation period for this to manifest itself as far as symptoms. The question becomes do we send them home.

Well, you know, we work 24 on and 48 off, so they can work at the end of their shift but it's not like we're going to wait until the next shift when they come back to work because the results of this test kind of fall into the same timeline as the first onset of symptoms if they're going to have it an exposure issue. You know, because the testing of the patient coincides with, you know when they would come down with symptoms and if we send them back to work, we have an issue.

So, what I'm doing is I'm going to put them off work and once I put them off work and if the patient test positive through the testing, I'm going to – there are – they're going to be off work for 21 days. I mean that's just we're going to have to do. Now, here's the big question, what do you with – we can say that you got to go home and you can't leave, how do we enforce that, one?

The other is what do we do with their families if they go home to five children who are going back and forth to school, you know? And how do we know when the exact onset time period is that they would have been exposed as a family to this individual who is – who had been sent home for essentially self-monitoring? And that would be the phase 1 part of this but I, you know, we need the answers to and I'm going to leave this open for a little bit discussion but then I like to ask phase 2 question. I'll explain what that is then.

Charlie Hunt: Very well. This is Charlie Hunt. I guess, you know, the one thing that is important to that is that you as the employer will not be responsible for ensuring the restricted movement and monitoring to occur. That would be up to the local health department or to KDHE. So again, it's not just that you send them home and say see you in three weeks, the local health department would be actively involved and making daily contact by phone with that person to monitor for symptoms.

John Paul Jones: But that doesn't answer my question, I mean go ahead, I'll let you finish first but I mean as far as self-monitoring and all that, I don't feel like that answers the evidence-based kind of science, the chain of custody of this. Isn't there an issue with – when they become symptomatic and they're sitting there and staring at their four or five kids, you know, they've taken their temperature let

say three or four times a day and they're calling in but if they become symptomatic at some point in time while they're with family, what do we do with that issue? Because I don't – it's not – I don't look at it as what my responsibility where it starts and stops officially, I look at it ethically and morally. I mean I want to take care of our personnel.

Robert Moser: Yes, very good point and if we are going to use the science, let's step back and look at the 48 immediate contacts of Mr. Duncan, the first index case. You know, they're almost through their 21-day incubation period and none of them have contracted the disease. And most of that has to do with – that your contagiousness is really not present until you begin to show symptoms.

So my thought as you're going to walk through the scenario is indeed you're sending them home. Upon arrival to home, you know even though they may have donned and doffed appropriately but with – they were wearing the same clothes, were under all that equipment. You know, I would certainly tell them they have to assume everything they're walking home in could be contaminated.

I would recommend and manage it accordingly, so is isolated in the home and washed and, you know, immediately and they shower immediately. All of that just once more before they have direct contact with their family. Then from there, they're not likely to be contagious unless they begin develop symptoms.

At that point in time, then obviously we'd be removing them from the home and the family exposure before they be shedding a large enough viral load to be of high risk to their family.

John Paul Jones: Right but I think that could be a scary situation as far as – I mean and to me it almost seems unsound as far as science that they – at what point do they become contagious? There's going to be a point where they're at home and they are symptomatic and therefore contagious. It just seems like that's a – that's huge risk like a blind spot right there.

As far as the clothing, what we intend to do is have them wear the protective clothing. We're going to overkill it a little bit as far as the running the call but as far as the clothing, et cetera, that's all going to be left at the hospital, you know, and that to me that's – it's, you know, I'd rather throw away a uniform than take an unnecessary risk here or be laundered through the hospital facility.

We're arranging for that right now but as far as, you know, just the – if it were me and I was sent home and say don't come back for 21 days because the patient that you transported was tested positive for Ebola, you know, my question would be what about my family and if I become symptomatic and I don't necessarily know it, you know, because I think the gentleman who died from Ebola in Texas didn't exhibit the symptoms of fever.

Robert Moser: Right.

John Paul Jones: It seems like there's a blind spot there as far as whether or not they could contaminate your family. That's the answer I don't have for my personnel and I have 436 firefighters that are going to be asking.

Robert Moser: Right, right, well I think you point out two things. One is that we're recommending, basically in our guidelines, it talks about the fever but more importantly if you have this exposure and you got any symptoms and obviously we're coming into flu season, so a number of other things could be causing symptoms but that should not rely on a specific measurement of the temperature I think act on the concerns that they could be exhibiting symptoms of Ebola.

So if we work with that and early onset of any symptomatology, regardless of the temperature would get them isolated, back out, away from the family long before they would be highly contagious, and that's really the best. Otherwise, we're talking about finding locations where these folks are isolated away from family for 21 days and I think that's overreacting but it may come to that as we learn more about the method.

John Paul Jones: Right, because you said highly contagious, I would think if it was my family, I wouldn't want to have it be, you know, situation or you know contagious at all

that they be exposed to because of something that is 50 percent fatal, you know, and so I mean I think it needs to be considered to that question, maybe it's the hard question. What do you do? Do we – you say that you have to be isolated.

Robert Moser: Yes, I think we still have to base it on the science which again the likelihood of being contagious is nonexistent until they begin to develop symptoms.

John Paul Jones: Which I'm – what I'm saying is the science to me says that they would be exhibiting symptoms and there's going to be a time period where they're exposing others, that's going to happen and there is the risk there and should we be providing for that risks and do we consider an unnecessary risk, should we be opening that door and having that blind spot because the science does say that there's an opportunity for them to be contagious in the presence of their family because you're sending them home until they exhibit the symptoms, when they – you don't know if when they're going to exhibit the symptoms, whether it's day 2 or day 14.

Where are they going to be, who are they going to be with, who's coming and going and if they don't exhibit strong symptoms and maybe they, you know, they don't immediately act on it, then those who coming and going can also be contagious elsewhere within two days? And that's what concerns me.

Mindee Reece: Yes, and I think those are valid concern. This is Mindee Reece and we will take all of your suggestions, comments, and questions under advisement as we move forward with our planning.

John Paul Jones: Sure. And the other question I have is phase 2 would be – I mean as far as looking down the road at what the potential is. I mean we're talking only six cases of the United States right now I believe is the number, so you know I understand that we're not there yet but I guess my concern with, you know, transporting 18,000 patients a year is that if patients were to show up in hospitals with the symptoms but not the history and then also test positive for Ebola, then we entered a whole new realm here where the screening based on, you know, like our dispatch center and that they're asking the right questions, we're gathering the intelligence and then we have the high risks.

But if – I think we have to kind of plan for what may happen if patients start to have – show up at the hospital with flu symptoms and test positive for Ebola without the history, then it becomes a very difficult to manage.

Robert Moser: Sure.

John Paul Jones: We probably transport a couple of hundred patients a year just with flu symptoms.

Charlie Hunt: Right. This is Charlie and the scenario that you're describing wouldn't occur because without the appropriate travel history, no patient will be tested.

John Paul Jones: Right but doesn't mean they can't – I mean what I'm saying is if this were to spread a bit to where it's beyond those that came from or where there was a direct relationship with somebody from West Africa and that the contamination occurred as cross contamination elsewhere, you know, out in the public and that person doesn't know who had that history but yet would exhibit the symptoms. I guess they would eventually be diagnosed with it if they in fact had it, you know, that would be a different scenario that I think is real one that could happen.

Mindee Reece: John Paul, you have said some interesting things to think about this morning and we appreciate your input. I think (Brandy) we probably need to wrap up now. I know there might be some callers still in queue with their questions. If you still have questions and they're clinical in nature, please call the Epi hotline at 1-877-427-7317.

Mindee Reece: We also have a new email address that we want to give all of you to direct your questions about Ebola too. It is response2014@kdheks.gov. R-e-s-p-o-n-s-e 2-0-1-4@k-d-h-e-k-s-.-g-o-v. I'll repeat it one more time, response2014@kdheks.gov.

This call has been recorded and a transcript was requested, so both of those will be posted on our KDHE Web site by early next week hopefully barring any challenges.

We will have a weekly population health call, so next week we will have another discussion about Ebola and provide more situational updates and any changes to our plan. As Charlie stated, the updated plan that he previewed and discussed today is posted on our Web site. So if you go to the KDHE Web site, which is kdheks.gov and you click on the button that says Ebola that will take you to the latest information.

So, we appreciate everyone joining the call today and we will send out the information about next week's call as soon as it's arranged. Thank you all.

Operator: This concludes today's conference. You may now disconnect.

END