

**Ebola Update Conference Call
October 23, 2014
10:00 a.m.**

Mindee Reece: Good morning everyone. This is Mindee Reece. We have a full house this morning. Without further ado, I'll turn it over to Dr. Moser who will make a few comments and then we'll move forward to our agenda. Today we will receive a situational update about Ebola and an overview of our Ebola preparedness and response plans, and then we will take questions and answers.

Robert Moser: Good morning. I certainly appreciate you taking time to be with us on the call today and for everyone here in the Departmental Operations Center (DOC). I wanted to just point out a couple of things. I know there is a lot of activity going on across the state with many of our partners, and I appreciate hearing a number of views and that you are sitting down with the healthcare system, public health, county commissioners, etc., to walk through your preparedness and response plans now that you have our revised response guidelines.

We're grateful to have Charlie Hunt with us today. I did want to point out a couple of things. One is to be mindful that we have a number of vaccine-preventable illnesses that we should also be focused on. Continue to recommend the flu shot at this time of year and the meningococcal vaccine for college age and young adults. Be aware that a John Hopkins scientist has posted something in the "British Medical Journal" that's getting a lot of activity on social media about the effectiveness of the flu vaccine and the increased side effects. It's great fodder for anti-vaccine folks.

It's just poor science, period. I can't believe that John Hopkins would allow one of their scientists to produce such a document, but just be aware of that. There is some great information out there that counters

many of these false claims. We will try to make sure that we post some of that on our website for you.

Finally, many of you've taken advantage of our communication channels that we've initiated with the Ebola response, including our "Response2014@kdheks.gov" e-mail account. Certainly recommend it, and continue to use that or the hotline. We've also added some folks to our phone bank to be able to address some of the public questions and concerns, as well as our professional inquiries. Please refer to that if you have any questions.

With that, I'll turn it over to Charlie Hunt, who will cover our planning and response guidelines and the changes we've made.

Charlie Hunt: Thank you very much and good morning everyone. I'll start with a very brief situation update from the international news in Africa. As of October 19, there are 9,911 cases in three countries of Guinea, Liberia, and Sierra Leone. There have been 4,546 deaths reported, still running above the 50 percent case fatality rate. On October 20, Nigeria was taken off the list of affected countries. It's been more than 42 days since their last case, which of course, is two incubation periods, so they've been declared Ebola-free for now.

An important part about the updated preparedness and response plan is that Nigeria was taken off the list of countries of concern. Anyone who has travelled in Nigeria after September 30 will not be considered at risk. Of course, we're more than 21 days past that.

The other highlights during the past week or so have been that CDC has released updated guidelines for infection preventions specifically related to personal protective equipment. I'll talk about that a little bit when I go over our plan.

The other thing that CDC has done was to announce increased entry screening processes for travelers that are coming in from the three

Western African nations that are affected by Ebola. I'll talk about that in a little bit more detail. We will have to consider what the CDC is doing when we consider our local response. Now, I'd like to go over the preparedness and response plan, and I'm going to focus primarily on the updates that we've introduced in this plan compared to what has been released previously. In general, we have provided just a little bit of a background and situation update in the plan.

I've given up trying to keep case counts updated in the plan itself because they're changing so quickly, and I just don't think it's worthwhile to have counts that are going to be obsolete within a day or two. We've updated our exposure category criteria. As I mentioned, we updated our monitoring and the healthcare and public health actions that have been taken for a person who has been exposed through Ebola potentially. We've added more detail regarding infection prevention, environmental infection control, laboratory testing and public health management of suspected cases persons who have been potentially exposed.

We've added detailed packaging and shipping guidance for laboratory testing, and we've also added a section on animal management for those who might be infected. I think it's important to start off with the entry screening now that CDC is doing it, because this is going to greatly impact the management of persons that are coming back into the country. CDC and customs and border protection are going to be screening at five airports. Up until now, they have screened 94 percent of all travelers that are coming in from those three West African nations.

Our understanding is that additional actions have been taken that have directed the airlines to funnel all air travel from those three nations into the five airports. In theory, we'll have a 100 percent of all travelers coming from those three western African nations in screening upon entry into the United States. The screening that CDC is conducting consists of an exposure assessment. It consists of a health

questionnaire that assesses any potential symptoms that are consistent with Ebola virus, and a temperature check that is actually measured when they are going through the screening process.

The passengers will be given what they're calling a care kit that will have instructions about active monitoring. It will include instructions about self-monitoring for symptoms, and it will include a thermometer. The passengers are given contact information for state and local health departments in the kit, and the expectation from CDC is that active monitoring by the state or local health departments will be initiated on a daily basis for all travelers that are coming in, which is actually consistent with the guidance that we released as well.

CDC will be sending us daily information about any travelers that have arrived and that are planning to come back to Kansas. Today we've not had any we are way far down the list, in terms of the numbers of passengers that are anticipated to come in compared to other states. But, if we do get anybody, that information will be passed through us. Our protocol will be then to initiate contact with the local health department and provide the information on the traveler.

My understanding is the information that will be provided to us will be the name of the traveler, all the contact information that they have and very minimal results from the screening process, whether or not any symptoms were present or whether or not any exposures were noted. Our process will be that we'll again contact the local health department. Because of the logistics, we anticipate that we actually will get that information the night of travel for that person or perhaps even the next day.

We will contact the local health department within four hours, and then we will initiate the screening process of the daily monitoring process. As soon as we contact the local health department, we will hand off the responsibility. The expectation is that the local health department staff will be responsible for doing the active monitoring. The plan has the

tools and the guidance for doing the screening process, along with the log given to passengers for keeping track of their symptoms. The care kit that CDC is providing will also have information.

Those are probably the biggest changes in terms of the screening and active monitoring process. With respect to the updated personal protective equipment guidelines, we have detailed in our plan two tiers for personal protective equipment for healthcare workers who would be evaluating and potentially caring for a patient with confirmed Ebola virus disease. I don't want to take the time to go over those in detail right now, but essentially -- there's a difference.

The primary differences between those two levels of personal protective equipment with respect to the public health management of those staff is that if the staff are using the highest level of PPE that we are recommending, they will be subjected to active monitoring for 21 days after the last potential exposure to the patient, but they won't have any additional movement restrictions with the exception of no travel by commercial (conveyances). Other than they won't have any moving restrictions.

If less than the optimal level of PPE use is used, then the healthcare worker will be restricted to caring only for that Ebola patient as part of the dedicated team that will not be able to care for any other patients. They would also be have their movement restricted for 21 days, and that includes being restricted to home, no visitors, et cetera, unless there is express permission provided by the local health department or by KDHE.

We are going to have a subsequent teleconference today with our network of infection prevention throughout the state, and we're going to be going over the guidelines in detail. I think it's important to note that when CDC released their updated PPE recommendations, we did a cross walk compared to our recommendations, which were published before CDC came out with theirs, and we're actually very close to what

CDC recommends. There are a few differences here and there, but CDC obviously increased the recommendations for PPE substantially over their initial guidance.

It was updated primarily with respect to providing more detail on packaging and shipping and invoice management and with animal management. I'll touch very briefly on animal management. If we have a confirmed Ebola case and that person has animals at home, there are not a lot of studies or science to base our actions on here. Quite frankly, we've taken what we think as a common sense approach that the animal should be quarantined for a period of 21 days and monitored for symptoms.

We're not recommending daily temperature checks for the animals, but if they start exhibiting symptoms that indicate an illness, then the animal should be examined by a veterinarian to see if they can determine the cause. If nothing can be identified, then call us and we'll consult the CDC and figure out what to do from there.

Robert Moser: I think we'll just go ahead and open it up to questions, rather than continue talking on a few other points. .

(Lee Banier): This is (Lee Banier) at Overland Park. We are long-term acute care hospital. We receive patients from the short-term acute. My question is related to, in the event we have a potential suspected case or an actual case, what is the expectation of our level of care for triaging, containing and treatment of that patient related to a time period?

Robert Moser: We appreciate the question and were hoping this would come up because we've certainly been getting a lot of questions from outpatient facilities and a number of other points of contact with patients. I think it's easy to think of using an acronym, (RAN). While we might like to run away from this issue, we need to look at (RAN), which stands for recognition, assessment and notification. We hope that everybody is

acutely aware of the need to look at identifying those patients with a positive travel history to those three countries within the last 21 days.

The earlier you can recognize them before they come into your system, the better. That means training those on the phones, those at the receptionist desk, and those who are accepting transfers within one system to another to be sure to follow up and ask questions. Then the risk assessment determines what category of risk they actually fall into, which helps determine what you should do then next as far as management and then begin stands for notification.

If this is a patient who somehow slips through and you determine that they have positive travel history and possible exposure to Ebola, you need to immediately isolate that person and begin to mobilize obviously appropriate PPE.

They're not likely going to be walking around necessarily to some of our outpatient facilities, more likely to be arriving through our emergency rooms or hospital settings. Some of them will be seriously ill. We know that that three feet should be the distance between a suspected Ebola patient and healthcare workers as a good protective measure. Universal precaution should be applied in all cases, regardless of whether we're dealing with Ebola or not.

If an outpatient facility believes that someone needs further assessment and risk determination, certainly you want to put on essentially the isolation gown, the double gloves, the face masks and N95 or surgical mask protection and even some head cover. All depends on whether that person is obviously violently ill and vomiting and you're dealing with bodily fluids. If that's occurring, you need the highest level of PPE. If they're not that ill, it's just the matter of assessing whether they carry a risk and need further assessment and then notification of KDHE and others. I think you've got plenty of protection within just an isolation gown, mask and gloves.

(Lee Banier): I guess to clarify the question; we're not an outpatient center. We're an inpatient center. We're classified by joint commission and CMS as a hospital. So what are the expectations of the State in the event that we had a positive case? How long would we have to maintain that patient before we would expect to see someone coming to retrieve that patient to relocate them to another location?

Robert Moser: The key is that you get patients transferred to you. Number one should be questioning the travel history before accepting the patient into the system. Number two - if they happen to have some of the developed symptoms and then later found out they've had some type of exposure, you're concerned. Again, immediately isolate them into a room preferably with its own bathroom and hold until testing and transport can be arranged.

If you believe you have a case, obligations are basically to contact KDHE within four hours of any suspected Ebola case on our EPI hotline. We will then help in making arrangements not only for the testing to confirm whether this is an Ebola patient or not, but also to make arrangements for appropriate transfer. We have an argument in place for an ambulance equipped with bio-containment units to safely transport a patient to another facility. We really want to limit the amount of movement for a potential Ebola patient to reduce possible contact with other individuals.

That's why we really believe if you've identified someone that you now believe is a risk, immediately isolate them in your location first and then start making notification so we can work together to make appropriate transfers and treatment decisions.

(Susan Cooper): Hi. I am still wondering about the sanitation requirements. I know that in Salina, the director of water management says that we can't put anything in the sewer, even if it has been treated. I asked Michael McNulty yesterday and he referred me to someone, but I haven't been able to get to them. So, I think there are probably other areas in the

state and I'm wondering what are we doing at the state level to make sure that the sanitation waste water folks have the proper information so that they can say, "Yes, if it's treated you can go with the waste in the sewer system," versus, "No, you're not putting these down" and then we have a far more exposure with untreated body waste in an isolation situation. So where are we at with that?

Robert Moser: I'll answer that briefly and I'll turn it over to John Mitchell, our director of the Division of Environment. We put in the guidelines that obviously we'd like to collect and treat the waste. Pre-treat the waste with a one part to nine part bleach solution and let that set before putting it down into municipal waste systems. We know that the virus is not very hardy outside of the body and bleach treatment is very effective and essentially disinfecting that waste and therefore making it safe to then dispose of in the regular sewer system.

If you're still getting resistance at the local level as far as allowing that, I would definitely recommend you contact our Bureau of Water folks that can help walk them through some other options.

John Mitchell: That's really a pretty good summary. Our response plan does contain information about not properly disinfecting waste generated, and I did know from previous conversations that leader of (Emory) University faced a similar situation. They were able to autoclave the waste and then dispose that at a later time. That involves onsite storage for some period of time until that could occur, but that is another option as well.

I think our preference would be to try to contact hem, the folks in Salina and the waste water treatment, and our public corps director and have a conversation about our best guidance and see if we can help them understand that the sewer system should remain an option, given proper treatment.

(Susan Cooper): OK. I appreciate that. We talk about autoclaving the waste. Most hospitals in the state of Kansas don't have an autoclave big enough to

do that. That's part of the problem, but I will get offline and talk with somebody from KDHE so that they can contact my local person.
Thank you.

Robert Moser: Thank you (Susan).

(Mary Winn): Hello and thank you. Our question would be transfer from out of our facility to other locations in the state. Have hospital larger tertiary care centers been established to accept Ebola transfer patients? Our difficulty is tests that require blood sampling could then contaminate the whole lab area. The waste stream is very difficult to keep sanitized. So your advise on transfers?

Robert Moser: We've been asking our hospital folks and realizing with larger number of critical access hospitals that capabilities of managing a confirmed Ebola patient can be obviously quite overwhelming, even holding onto someone while they're waiting for confirmation of the testing. Obviously it works to move the patients to the most appropriate level of care and provide the assessment stabilization prior to that and the acceptance by that receiving facility so you don't violate EMTALA.

We've really been asking the variety of hospital systems to look at their network of referrals and have the conversations between them as far as what the expectations would be for the smaller hospitals - on the amount of time that they would maybe need to hold onto the patient until the test is confirmed. Some of that may have more to deal with their level of illness and need for intensive care, rather than waiting on a confirmation of Ebola test.

I really think the conversation really happens among the hospital system first and then as we continue our conversations with Kansas Hospital Association and the other folks, I think then we can have some other ideas. I still, as a state health officer, believe that these folks should be managed in a bio-containment unit. That said; we don't have one in the State of Kansas.

The closest would be the University of Nebraska Medical Center. The requirement is that it has to be a confirmed case, and that we have to get approval from their state health officer and the medical director of that bio-containment unit before we could transfer. Between getting confirmation that it is Ebola and making arrangements for acceptance of the bio-containment unit, you can see that most facilities would be basically expected and managed as patients for two to three days while all that takes place.

It's still possible that the University of Nebraska or any of the other bio-containment units in United States may not accept the patients, even though Kansas would like to send them. Therefore, we still need to identify. I know there are larger hospital systems that are ramping up in training and preparing to manage Ebola patients, but at this time, I think it's ideal for the smaller hospitals and those that don't feel they have the facilities or the staffing to reach out to the hospitals they typically refer to, to make those arrangements.

Now as far as lab equipment, I would agree that if you have a case that you've been doing the risk assessments or determine if they have the positive case definition of foreign travel from those three countries in the last 21 days, I would be very reluctant to expect you to do any blood work and risk contaminating your laboratory equipment or staff until you've gone through that risk assessment and determine whether or not this is the suspected Ebola case that you're working for now.

(Harold Woods): Hi. Our question is relative to the new PPE guidelines. The guidelines only cover those persons that are actually in direct contact entering the room (caring) for the patient. Do we have any guidance or guidelines relative to the PPE observer or the buddy, if you will, the person that's going to be decontaminating the patient -- the employee when they come out of the room, that's going to be helping them doff their PPE et cetera? And what are we doing with that body and their PPE?

Charlie Hunt: Our recommendations are for anyone that's potentially exposed to Ebola virus. It's the language I've tried to use in this. So the expectation is to monitor service, particularly those helping someone doff their PPE. They're actually more than a monitor at that point - they are potentially exposed. And so they need to be in the same level of PPE.

(Harold Woods): But then how do they get out of their PPE?

Charlie Hunt: Well, they're very less likely to be contaminated. Most of the monitors watch the buddy don their PPE essentially behind a glass panel in those cases. All depends on your physical structure and layout, but the buddy system - each other helping to don and to doff - is appropriate. The monitor really needs to just to watch that it's been done properly, that they don't accidentally breach the protocol, such as their scanner or something else that needs to then be decontaminated at that point.

(Harold Woods): OK.

(Steve Granzow): The question I have is very similar to the last question with the (donning and doffing) - we're reviewing the videos from Nebraska Medical Center. It looks like they're using a lot of the disposable (paper) equipment that we do not that have. Also, the PPE we have is not suitable. Is there any financing in the pipeline to help us acquire this PPE. Because I read the note about KU Med Center yesterday, they had one patient that didn't even have the disease and spent something like a \$120,000 on PPE and other types of containment materials. Is there a revenue stream for that because I certainly don't have revenue stream that would approach that?

Mindee Reece: (Steve), this is Mindee. We do not have an earmarked revenue stream to cover the cost of those items. However, you have the Federal Preparedness Fund that is passed through to hospitals and local health departments. One thing that Ron Marshall with the Kansas

Hospital Association and I spoke about this morning is a plan to access the caches of personal protecting equipment that we have at the state level, some at the regional level, and some actual community hospital to have a cache.

We're going to try to develop a strategy to equip all of the critical access hospitals with at least a baseline of personal protective equipment that lines up with our guidance on appropriateness. That is something we're going to work on probably over the next 72 hours or so. Stay tuned next week because you'll be hearing more from KDHE and the Hospital Association on that.

(Steve Branton): OK Mindee. Thank you. What about updated training? Where are we aligning on the University in Nebraska Medical Center videos? Are we going to do any other training on PPE? Is there a way to come out? And one of ours is where are we going to, not so much of the donning as the doffing and then how to dispose those materials.

Charlie Hunt: We are working on a training presentation that will be distributed, and we'll provide additional details about that at a later date, but we're going actively right now.

Robert Moser: We also put out through K-SERV and other meetings looking for folks who would volunteer to be on a regional bio response medical team. They would bolster and support the facility if short-handed and need staff support.

We would like to equip the team with folks who are experts in infection management. We have probably 15 to 20 folks that have responded to that. The plans are that we indeed will be planning on doing some PPE training to essentially develop additional train-the-trainers to be readily available out across the state in a variety of communities to help with getting everybody ramped up and comfortable with managing this.

(Steve Branton): Well, thank you very much. I appreciate that, especially after sitting through the Texas Health Resources conference call yesterday. That was a very intense drain on their human resources, especially the nursing staff.

Charlie Hunt: Yes.

Robert Moser: Yes.

(Kerry Shike): Yes. We had question on the category A shippers. Who will transport those? We're under the impression that the commercial shippers are refusing.

Brian Hart: This is Brian Hart from KDHE lab, and as long as the package is marked as a suspect category A infectious substance, and has not been previously tested and Ebola is not on the outside of the package, FedEx will ship that package, and we also have other options if need be.

(Kerry Shike): Should I contact you?

Brian Hart: Yes. You can certainly contact me or the response 2014 hotline.

(Kerry Shike): Thank you.

Brian Hart: Yes. And just to follow-up on that, there would be essentially a case-by-case consultation with the Epi hotline and if the risk assessment is necessary.

Mindee Reece: If you need to contact the Epi hotline, the number is 877-427-7317.

(Kerry Shike): Thank you.

(Lori Flore): Hi. My question is regarding workers as far the Special Consideration for Healthcare Worker that was released here a couple of day ago that

Kansas Ebola Preparedness Response Plan. One of the things that I needed further clarification was for the highest risk of PPE they are not restricted, they can continue to work correct for 21 days. So they can't see other patients. Is that correct?

Robert Moser: Yes. Correct as long as obviously no needle stick, no breaching the protocol witnessed by the monitor et cetera. Essentially, once that happens, then they're on that restricted movement and temperature monitoring category.

(Lori Flore): One of the questions that came out yesterday from our work group was we have a emergency room positions that will probably be the ones who are going to get the highest risk of contact before PPE is donned. If he or she is exposed, would they then have to be quarantined basically for 21 days? There was some concern about their licensing and what they're allowed to do, outside of the ED area.

Robert Moser: That's a credentialing question for the facility that we really can't answer, but you bring up a perfect scenario where if it's meeting someone to assess or intervene on a patient with the skills that perhaps your staff doesn't have. They could be part of Ebola care team but once they would leave the facility to go home, they would have to be essentially restricted in their movement because of their exposure in the emergency room.

I'm sure they would much rather find something to do and some activities to be involved in and caring for the patient may be an alternative, but again each facility will have to determine how they will handle the credentialing and issues around that.

Charlie Hunt: I do want to go back and just revisit one of their earlier questions regarding the monitor. It's one of the things we realize in our guidance that did not delineate those two responsibilities like the CDC guidance did. We will be walking through our guidance and providing additional information about that shortly.

(Kellin Young): This is (Kellin). The CDC has very detailed directions on donning and doffing PPE and they include the person that is observing the doffing, actually the donning and doffing. Why is KDHE not following CDC's guidelines for donning and doffing?

Robert Moser: And where are we not following the donning and doffing? I'm sorry.

(Kellin Young): Well, like the person that asked about the recommendations for the person that is observing and CDC has very specific guidelines to the person that is observing....

Robert Moser: Right. Those and that PPE is pretty much what we described for those folks in the outpatient setting that aren't necessarily dealing with patient that's actively ill with the body fluids and what not. Since they're mostly in there to monitor, the PPE is essentially the disposable fluid resistant or impermeable gown extending to at least mid-calf or covering the lower leg down to the knees or little bit below, the face shield, disposal nitrile examination gloves.

Outer gloves should go over the cuff and then the fluid resistant are impermeable suit covers. Essentially it's the same type of PPE we're talking about with those folks that are worried in the outpatient setting that they may have someone through either questioning on the phone or the receptionists that they could be a high risk Ebola patient. They want to go in to examine or to evaluate the patient with further questions and that same type of PPE as the observer who is watching the donning and doffing, if they're there to essentially monitor or assist.

(Kellin Young): OK. And I have another question. If Kansas gets notified there is a patient that is coming into Kansas that has been identified - that has flown in and is identified, is our local health department going to be notified and local hospitals?

Charlie Hunt: This is Charlie Hunt. I want to clarify the difference regarding a person that's coming back as a traveler. That information will be related to us and we in turn will relay to the local health department to conduct active monitoring. Right now, there are no plans unless there is a very good reason to share that information with the local hospital. I don't see the need to do that.

Male: Regarding the waste water, is KDHE just going to simply contact all municipalities with waste water treatment centers to get them a standard guideline so that everybody is on the same page because you're wasting time with individual municipality having to be contacted by KDHE individually? Can they reach out and contact municipalities as a group and set the guidelines and have them follow on or is it legality issues as far as the rights on the municipality and what they want to allow into their treatment centers?

John Mitchell: This is John Mitchell, KDHE Director of Division of Environment. Yes, we can reach out and provide guidance to all of our waste water treatment facilities. We did not have the ability to say you must receive this waste. I think that would have to be a local decision made, or we can certainly try to provide sufficient guidance and information so that the decisions can be informed and hopefully that will take care of many of these problems.

(Kellin Young): Well, thank you.

(Karen Brooks): Yes. Our question is about availability of PPE. We have a very limited supply, and we were trying to get up to a supply of five days or so for our teams. We are getting backorders on almost everywhere from eight months to a year availability of the suits and hood. Goggles also are a problem.

Robert Moser: I appreciate that, Karen. Three of the calls yesterday I was on with whether it's HHS, Homeland Security, CDC et cetera they definitely

brought up the hospitals and community concerns on availability of PPE. At this point, there has been obviously a very hurried rush on ordering the systems, or they tell CDC they've got adequate supply. It's just trying to sort through all of these various orders in order to basically prioritize them. More than likely, you're going to see prioritizations similar to H1N1 with the flu vaccines going to those more populous areas first.

You can imagine the five cities that have the airports where they're directing these patients. They have to first assure that they have adequate PPE supplies since they would be perhaps more likely to have these contacts. Then those destinations in the U.S. where the majority of those folks travelling in from those three countries would probably be your second tier, and then, unfortunately, everybody else follows into that third tier.

They are rapidly trying to access and reevaluate just exactly where the bottleneck is, but at this point in time, and in most of those electronic ordering systems that many of those vendors use, they are overwhelmed to the point that we're seeing a lot of concerns about eight months to a year, year and half before they'll get shipment. I don't believe it's necessarily going to be that long, but I understand if you're short and don't have the adequate amount of PPE. As many mentioned earlier, we've inventoried what our state supplies are and we're reaching out to look at a number of the regional and even local.

Certainly get back with the folks who will make that information available if you absolutely are short of inventory. Also, please get in touch with Mindee or I and the hospital association will work on that. Reach out to your neighbors as to what their status is and whether they may have a supply until such time when you will get your shipment in.

(Karen Brooks): I've kind of done that and so far we have not had any luck with that, but I do thank you guys for working on it. However, I hardly have enough

people that will say they'll work with Ebola in the first place. It's not going to be good and we still are operating under EMTALA, so we still have to take the patient. It doesn't make any sense.

Robert Moser: I know it's a challenge and that's partly why we're also looking for the regional bio response teams. The volunteers recognize that more training and more experience use of PPE increases the healthcare workers resilience and acceptance of working with scary things like Ebola. Folks that have had more advanced training on PPE in healthcare settings have been focused more on the chemicals, but this is very similar. It takes practice, time, and education to get to that level.

We realize we've got some work to do, but we appreciate what you're working on there.

(Mark Miller): Good morning. I think we've already touched on this, but I wonder if serious consideration has been given to treating the smaller hospitals much like you were an outpatient clinic and getting these folks focusing more on the transportation so that we can get as a suspected patient to a larger facility. That would allow us to concentrate, the expertise, the training, the limited supplies and equipment. Of course, larger facilities are better staffed and have better facilities than what the smaller hospitals do.

Robert Moser: I appreciate that point and that's where we want to get to. The referral networks have these conversations, and the hospitals identify what their abilities are and willingness. We can't dictate a non-profit or for-profit healthcare system and what they certainly should or shouldn't do, or at what level they should operate. If we look at our risk assessments on disaster emergency preparedness, while Ebola may not be very likely, there are a number of other issues where this type of training is important.

I certainly agree with you for the time being. This is front and center and we are identifying how Kansas healthcare system would handle this situation. I believe you're absolutely right that for critical access hospital the recognition, the risk assessment, adhering and referrals makes appropriate sense. The key is though we don't want to continue to expose additional healthcare workers to later positive Ebola patients, that we're happy to get the system in place to make sure we limit those contacts.

(Mark Miller): Thank you.

(Karen Hendricks): Hi. My name is (Karen Hendricks) and I had a question. I was reading on the CDC guidelines for environmental infection control for healthcare facilities back in 2003, and we don't have anti-rooms for our isolation rooms and it recommends using a portable industrial grade HEPA filters in the patient rooms to provide additional ACH equivalence. Is that something we still recommend? And is that just a portable unit that we would have to purchase?

Robert Moser: We realized that some of the physical layout for managing intensive care type patients particularly with this form of infectious disease may not have a dedicated room to basically make that transition from hot zone to cold zone very easy. Some of the recommendations coming from a variety of the facilities that have dealt with not Ebola, but with similar type issues talked about whether to create a room in the hallway shielded off from a regular patient or staff movement. Without knowing what the physical layout looks like, it's hard to say what the options may be.

There are other pieces of equipment that may still work within the room system and set up that you have. The aisle chamber, which is essentially kind of isolation chamber that goes around hospital bed that has its negative airflow and have the filter combined into that. Some of those are nine by 10, 10 by 10 type sizes. I think if you want to visit with this offline perhaps about what your physical layout looks like, we

might be able to point you just some resources to look at and visit with your administrator and health facility folks about the applicability of some of that.

Operator: Your next question comes from the line of (Ted Arnett).

(Steve): Good morning. This is (Steve) and actually my question is referencing pages seven and eight of the document. It talks about prior to doffing you don't have to do the travel restriction because the suit can be washed and disinfected prior to doffing, but I don't see anything in the guidance about what that would look like. Is that going to be part of the training as it comes out?

Robert Moser: Yes, depending on the type of PPE suits that you're utilizing and what the physical set up of your hot to cold zone looks like. The training usually would incorporate decontamination or disinfection as you move from the hot zone to the cold zone.

(Steve): OK. So then it will be part of the training videos and everything. I know UNMC has it in there. I just wondered if we're going to address it.

Robert Moser: Yes.

(Steve): OK. Thank you.

Mindee Reece: I'm sorry. This is Mindee. We're running short on time. We have an infection call right after this call. So we'll take one more question and then we'll close with the few comments and others on the line that haven't been able to ask their questions, please send those to response2014@kdheks.gov or call the epidemiology hotline at 877-427-7317. We'll take one last question.

Operator: OK. And your final question comes from Susan Boyle.

- Susan Boyle: Good morning. Thanks for taking our call. I am a school nurse, and I was curious of the recommended proactive approach for school districts for screening and response, and at what time do you recommend a search screening?
- Charlie Hunt: Good morning. This is Charlie. We hope that you won't end up having anyone in your school that have gotten through the screening process, but if for some reason you have a student or staff person that has been travelling within one of the effected countries in the previous 21 days and has not received the risk assessment, I would recommend that you contact your local health department and coordinate with them to make sure that that gets done; and then, the local health department will actually be doing the acute monitoring process, not the school nurse.
- Susan Boyle: OK. So, at this time, you don't think it is necessary for us to take any proactive measures as far as screening a child that comes into the office with a fever?
- Charlie Hunt: Once again, it will be only those students who travel within one of the effected Western African nations within the previous 21 days that you would need to be concerned about.
- Susan Boyle: OK. Thank you.
- Charlie Hunt: If that student has not had a risk assessment done, then we need to coordinate with local health departments to ensure that it gets done.
- Susan Boyle: OK. Thank you.
- Mindee Reece: Thank you. I want to remind everyone that we're not going to have our usual monthly statewide population health call that was scheduled on October 28. Rather, we are going to have another statewide call on Ebola next Thursday, October 30 at 10 am. I want to apologize. We had a typographical error in our phone number on our website today

for this call. So I want to give you the number for next week so we avoid pitfalls.

The phone number for this call, which is 10 am one week from today, on October 30, is 877-388-6280 and the conference code is 22753666. I'll repeat that one more time. The number is 877-388-6280. The conference code is 22753666. That adjourns our call for today. Please keep in touch if you have other questions or concerns, and we will be providing updates via the Kansas Health Alert Network.

If have not registered for that system, we encourage you to do so.

Operator: Thank you for participating in today's call. You may now disconnect.

END