

Regional Health Care Coalition Ebola Preparedness Forum
Hays Medical Center, Hadley Room 2&3
Hays, Kansas
November 24, 2014

Welcome and Introductions

Handouts: Agenda and Sedgwick County EMS Biosafety Transport Team (MERGe)

PowerPoint Presentation: Our Job: Prevent “dis-ease” as well as “disease”

Dr. Robert Moser (Secretary, Health Officer), Aaron Dunkel (Deputy Secretary), Charlie Hunt (State Epi) Myron Gunsalus (Laboratories), Mindee Reece (BCHS Director), Mike Tate (BOW Director), Terry McCue (MERGe), Angie, Jonathon, Toby (KDEM), Tami Wood (Healthcare Coalition Regional Coordinator), Samantha Ramskill, Laura Ross (KDHE Preparedness)

Introduction, Tami Wood

- Learn about Ebola Preparedness and what KDHE has planned; we are going to learn a lot of great things.
- 11:30 will be lunch.
- General housekeeping awareness.

Introduction, Dr. Robert Moser

- Why we are here.
 - We have been working on Ebola response plan since August.
 - Using disease investigation guidelines.
 - Towards the end of August got it out to all the local health officers, sent the first letter through the local health officers, the resources at KDHE.
 - Health officers got signed up for KS-HAN, up the situational awareness.
 - KDHE just put out version 4 of the plan
 - Version 5 will be based on these discussions
 - Kansas has been consistently more aggressive than the CDC
 - Addressing anxiety about Ebola, until we have more education and more references
 - PPE: fact the CDC started with the mindset, that any hospital should handle Ebola patients. And the PPE wasn't even at the standard of W. Africa. We thought more aggressive form of PPE was necessary for the safety of Kansas until we had more information and training.
 - The KDHE team has been traveling through all the hospital regions.
 - Discuss the Ebola response plan.
 - Open discussion.
 - Question and answer session
 - Will not leave until all questions are answered!
 - Questions will be converted into a FAQs
- KSERV
 - A lot of people have signed up through KSERV.
 - 40 people have signed up to be on the bio response team, no doctors, yet

- This team will be dispatched to back fill to cover their internal Ebola response team.
- Dr. Moser moving to a different position, so he can now participate as a physician responder.
- Importance of partnerships and working together in the healthcare field.
 - Elevated the importance of working across the disciplines
 - Need to partner and recognize the roles and responsibility of each discipline
 - [Doctors] can get lost in the case of the patient, not necessary all the public health side.
 - Public health is responsible for the disease tracking
 - This is one of the largest outbreaks in W. Africa ever.
 - It is important to recognize the importance of partnering up and working together.
 - Always ask the travel screening questions.
 - Continue to listen to the population health calls

Situational Update, Charlie Hunt (PPT presentation)

Overview

- West Africa, status of the outbreak As of, November 13, 2014 Brief overview
 - >14000 cases, two outbreaks of EVD, mostly in Guinea, Liberia, Sierra Leone. Liberia most impacted.
 - Outbreak started in December. WHO announced in March an outbreak was happening.
 - The WHO has traced back to a 2 year old child as the first case.
 - Then on to others, then viral
 - The environmental conditions in West Africa are a breeding ground for the Ebola cases.
 - Liberia was the most impacted.
 - Liberia cases have gone down.
 - Sierra Leone has more cases, it is getting worse.
 - Mali is a new threat
 - One case earlier in the fall with one death.
 - New cluster of cases reported not connected with the original cases.
 - 250 contacts being investigated
 - Travel notice on Nov.13.
 - US gets about 15-20 travelers a week from Mali
 - Add Mali to travel history risk assessment
 - Democratic Republic of the Congo
 - Separate outbreak starting in August 2014
 - Soon to be declared Ebola free
 - If 42 days have passed from the last case then it is considered Ebola free
 - 42 days= two incubation cycles
- General Ebola Facts
 - First case of Ebola, 1976,
 - VHF natural reservoir most likely bats.
 - Not a virus that is normally present in humans.
 - Characterized as sporadic outbreaks.
 - More than 30 events since 1976.
 - Some outbreaks few people- hundreds.
 - Eight-ten day incubation period, max is 21 days.
 - Early on, the symptoms are not specific.

- Later on when the disease becomes more serious,
 - Gastrointestinal problems, then hemorrhaging.
 - Transmission
 - Direct contact with the body fluids.
 - Contact with contaminated objects, like needles and medical equipment.
 - Contact with infected animals.
 - Primates and other mammals become infected. If a person comes in contact with those animals that maybe how it gets into the human population
 - Contagious
 - NOT infectious until symptoms appear.
 - This is because the virus is transmitted through bodily fluids
 - Cure
 - No known cure
 - Treatment
 - Supportive care
 - The best and most effective care
 - Balancing fluids/electrolytes
 - Maintaining O₂ and blood pressure
 - Treating complicating infections
 - Concerns for the US
 - traveling in affected countries and coming back
 - Travel from W. Africa to Kansas is well within the incubation period
 - About 150 people a day
 - People are not coming in after being diagnosed
- US case review
 - Dallas: travel from Liberia, asymptomatic when he arrived. Liberia did exit travel interviews. He denied all contact with Ebola. His travel history was not communicated and he was allowed to go home, went back and then he died on Oct. 8.
 - Two nurses that became infected Oct. 12, Oct. 15, who cared for the Dallas patient.
 - Doctor in Guinea, returned to states Oct. 17, self- monitoring came down with a fever, he went to the hospital and was diagnosed on Oct. 23.
 - Exit and entry screening was being conducted.
- Quarantine challenges.
 - Nurse quarantined in New Jersey after medical care to Ebola patients in Sierra Leone.
 - Placed in the tent and complained loudly of the conditions.
 - Lots of media coverage.
 - Released and placed under quarantine in Maine, she was to coordinate travel with Maine; her movement was not restricted, because she went to court, in Maine.
 - Judge did note that her behavior increased public anxiety and she should have “known better”.

Overview of Kansas Ebola Preparedness and Response Plan

Kansas Response Plan

Biological Incident Annex

KDHE-BEPHI Disease Investigation Guidelines

- Ebola Response Plan
 - Plan is a in coordination with the KS Response Plan (KRP)
 - KS Response Plan-Biological Incident Annex
 - KDHE-BEPHI Disease Investigation Guidelines
 - KRP
 - Very comprehensive documents.
 - Epi, lab testing, prevention control, applicable regulations
 - Updated with the Ebola Response Plan, since it wasn't in there.
- Overview
 - Risk Management
 - All travelers from the four countries will be routed to five designated airports.
 - MCI is not one of them.
 - Entry survey
 - Health screenings they will fill-out a survey to see if they participated in any activity involving Ebola.
 - Will be assigned a risk category.
 - If final destination is Kansas
 - Entry screening information is sent to KDHE the same day.
 - KDHE will send to the local public health department.
 - LHD will complete the disease investigation.
 - Appendix 1 of the plan
 - Risk Category
 - High risk: Patient care (with a breach in PPE)
 - We will ask that person to do the active monitoring process for 21 days.
 - Keeping track of their symptoms and checking their temp 2x day.
 - We will ask anyone to stay home and not have visitors.
 - Travel from the home, or visitors to the home should be approved by LHD or KDHE.
 - Avoid the potential exposure to public.
 - Make sure traveler has access to health care if they become symptomatic.
 - Some risk: providing medical care, or in contact with Ebola at some degree no high risk exposure
 - Active monitoring
 - Do not use commercial travel.
 - No known exposure (low/no risk): just in the country
 - Active monitoring
 - Do not use commercial travel.

Tier 1 Level PPE

- Includes:
 - Impermeable, single use coverall
 - Can have no hood, if the head and neck is completely covered.
 - Goal is to have all skin completely covered.
 - 2 layers of nitrile gloves

- PAPR
- Latex or rubber boot or single use impermeable boot
- While caring for the patient
- 21 days active monitoring
- Movement is not restricted
- Utilize less than tier 1 if they are doing patient care, must be on the dedicated Ebola care team (with restricted movement)!

Tier 2 PPE

- Includes:
 - Impermeable gown
 - Impermeable apron
 - 2 layers of nitrile gloves
 - N95 respirator
 - Full face shield
 - Shoe covers
 - Goal: cover all the skin!
- Must be on the dedicated Ebola care team.
 - Care for that patient and only that patient.
- Patients presenting at the hospital
 - Conduct screening for all patients
 - Post posters to help with screening.
 - Must ask about travel history.
 - If within 21 days of travel to one of the affected counties
 - If they have symptoms consistent with Ebola
 - Ebola Patient Suggestions
 - Restrict visitors to hospital.
 - Avoid entry of visitors into patient room.
 - Exception on case by case basis.
 - Log all persons entering/exiting room.
 - Including health care professionals.
 - Provide instruction to all visitors.
 - Hand hygiene
 - PPE instructions
 - Review the visitor PPE protocol in your hospital.
 - Dedicated medical equipment for Ebola patient.
 - Ensure to follow disinfection processes.
 - Limit use of needles and sharps or other techniques that may increase the potential exposure to healthcare workers.
 - Limit diagnostic testing.
 - Laboratory testing to rule out EVD.
- Notify KDHE
 - Must call within four hours of knowing about patient.
 - Epi hotline-877-427-7317
 - Will walk you through the careful assessment of the patient history and clinical picture.

- Intensive case and contact investigation
 - Use VHF disease investigation guideline as basis
 - KDHE will work with local health department.
 - CDC will not test on demand, must go through KDHE.
 - Risk assessment process is very important.
 - Only the CDC and the Level 1 LRN laboratories will test for Ebola.
- Specimen collection
 - KDHE website has the information.
 - Consider American Society for Microbiology guidelines.
 - KDHE has adopted this at the laboratories.
 - Guidelines call for POC testing so they don't go to the laboratory for testing in the hospital.
- Movement restrictions
 - Work within the community to make a plan.
 - LHD and other agencies, to think about how the restricted movement process will work at the local level.
 - Make restrictions are easy as possible,
 - Try to take care of basic needs: groceries, entertainment etc.
 - Being home for 3 weeks can cause emotional distress too.
- Waste management
 - Flow chart in the plan.
 - If a patient occurs in a hospitals, and how it will be handled.
 - Environmental cleaning and disinfections:
 - Tier 1 PPE should be used.
 - Use EPA approved disinfectants for non-enveloped virus, label will read: norovirus.
 - Bleach solution will also work.
 - USDOT has classified Ebola virus as a Category A Infectious Substance,
 - Must be handled using the hazardous materials regulation.
 - DOT shipping packaging adequately satisfies the hazardous waste storage regulations.
 - DOT has issued a special permit to ship Ebola waste.
 - KS has determined Ebola medical waste as a Category A hazardous waste.
 - All waste materials should be sterilized onsite, then it can be managed as regulated medical waste instead of hazardous waste.
 - Autoclave guidelines
 - Make sure to use a chemical or biological indicator strip.
 - CDC recommendations now appear to be consistent with WHO.
 - Types of waste
 - Patient care waste
 - All vomit, diarrhea collect as hazardous waste.
 - Can be treated with a bleach solution (1 part bleach 9 parts water) then released to the sewer system.
 - KDHE suggests treating the toilet with a bleach solution before adding waste, then waiting ten minutes, then flushing.
 - Environmental waste
 - Large or bulky waste inside the home
 - Treat with WPA registered disinfection or bleach solution.

- Avoid breaking things down.
- Isn't known to be infectious from inanimate objects.
- LHD
 - Identify resources
 - Local HazMat teams,
 - Refer to CDC guidance for residential cleanup.
 - Can be performed by family members or other residents of the home.
- Human remains
 - KDHE has adopted CDC guidance.
 - KDHE recommends remaining in Tier 1 PPE.

Open Discussion/Question & Answers

1. **What do you recommend we do with the Tier 1 PPE after we are finished caring for the patient? Can we reuse the suit?** Use the suit once, and disinfect the PAPR. But the suit should be disposed, since it is a single use suit.
2. **If there is a shower in the patient room, should we decon in the shower?** Do not use the patient room. Remove PPE according to your protocols, shower after the PPE is off. This also depends on the physical layout of the area where patient care is happening; if there is gross contamination you can decon the PPE in the patient shower, and then move to the designated area to begin the rest of the PPE doffing protocol.
3. **If you have a person at the HD with restricted movement, and they decide not to be restricted, does the law enforcement have authority to make them remain in quarantine?** Local health officer is responsible and they have authority. If the person is reluctant, make sure you are addressing the person's needs. If you have someone who simply refuses, then the health officer can issue quarantine orders, we don't want to do that, because then the person will be made to stay by law enforcement. Day 14-day 15, talk with the LHD and the local health officer, we might allow more movement or freedom to move. The health officer will and can talk with the law enforcement to help. In Kansas, we have a lot of community pride, and the community will pull together to ensure the needs of the people met. Over here our health system doesn't understand why someone wouldn't want to isolate themselves. Public health is always thinking about the health of the public.
4. **What is a level 2 travel notice?** Practice enhanced travel caution. Similar to a warning, even for the other three countries, travel is still being allowed, any volunteer work is still being allowed.
5. **Will we have access to the slides?** Yes they will be posted; they will be updated with the plan updates, so it may not be the exact same PPT presentation. Look for those updates on our website.
6. **Prior to donning PPE are you recommending hospitals to wear scrubs or shoes? Can we autoclave these items or do we throw clothes away?** You can usually wear your own scrubs under coveralls. Shoes, Nebraska Medical Center suggests wearing shoes like crocs because they can be cleaned and disinfected. The facility may provide scrubs to prevent cross contamination outside the facility. If

provided, don the provided scrubs, provide care, doff scrubs, shower and put back on your street clothes. We have no direct guidance on the shoes. Refer to your hospital protocols.

7. **If we are doing a four day stretch can the facility wash the clothing?** The facility needs to determine their protocol. This will come back to how the hospital determines their protocol for managing PPE. Each facility needs to work through how they are going to manage this so there isn't an incident.
8. **How many people plan to go back to the countries for holiday?** We don't know when they leave; we know when they come back. Once again, when they come back, they should undergo the screening process, the information will be sent to KDHE and KDHE will tell the LHD and then the LHD will start the screening process. If the traveler is low risk they will not have their movement restricted, only participate in active monitoring. Any foreign students may want to go and come back to the US early so they can do the 3 weeks before classes start.
9. **Restricted monitoring and movement: What happens if the husband is being actively monitored, what happens to the wife and kids at home?** We have not addressed in the plan. That will be up to the individual to assess his threat level. If they are high risk then they need to consider their family members. Maybe have a separate bathroom; remember the likely hood of transmission early in illness is VERY low, all the contacts, even in the first case in Dallas, no household members became infected. The transmission is only in the late stages of illness. At the first sign of symptoms the patient needs to go to the hospital. Before any symptoms are present, there really is no risk.
10. **Regarding Tier 1 PPE. If utilized correctly, can the doctor and nurses still treat other patients?** Yes. If they use less than Tier 1, then care is restricted to that patient, remember no breach in the PPE protocol. They will participate in active monitoring, but no restriction, in movement or providing care. That level of PPE and observation they should be able to move and treat people while posing no risk to other patients or the public.
11. **Public health question about management of the monitoring people, I understand not contagious, but how do we handle their waste products? My family has a lot of trash!** Nothing different. They can throw their trash out normally, just put the trash on the curb. **It wouldn't take long until community knows, and to become uneasy,** until they exhibit symptoms, [LHD] is only isolating to monitor, do not do anything different with the patient's trash.
12. **Concerned about the college student travel issue. We have eight students at Fort Hays going back to Africa. Board of Regents are suggesting they travel and come back in time to complete the 21 day monitoring; this will be very difficult since you have young kids instructed on what to watch for as they are being monitored. All this is based on honor systems and common sense, are we actually instructing them HOW to take temperature, they go to class, they don't feel good, they go home and then they go to the nurse and now that kid will have to be hospitalized because of symptoms until there will be a rule out of Ebola. In January there will be an issue on some campuses. We are depending so much on the kid's common sense. The kid might think it is something else and go to class, there is some common sense we have to deal with or we will have a problem. How many kids will develop a cold, and not Ebola, Hays Medical can take care of 1-2 patient? Just think of how the parents of a kid in that classroom with the kid from Africa are going to react.** Good question, we have had some discussion. The health officer can isolate the students, from the process outlined in your own

plans. **They are not living in a home, they live in the dorm. Classes aren't gigantic; Fort Hays isn't like KU.** There is a lot of anxiety, we have made the suggestions and recommendations and they must determine how they want to manage their school system. There are many holes and gaps and the local HD and the schools will have to find a way to isolate those students for the active monitoring and tracking. Each school's tactics will be unique to their students. **How do you manage them?** KDHE will continue to visit with local HD; every school will be uniquely different. We try to stress, it is not just contact, and it is contact with bodily fluids. Only when/if the student develop symptoms is it contagious.

- 13. How is a small facility with 15 nurses going to follow the PPE guidelines and the restrictions?** KDHE is using KSERV, as a potential for us to identify health care professional to backfill or provide care for the Ebola patient. Remember use of the Tier 1 PPE allows for no restricted movement.
- 14. How will MERGe be used for patient transport? What is a MERGe team?** MERGe team is a group of EMS professional specifically trained to assist local EMS systems that have used all their resources, because none of us have the resources to transport. Merge team is a conduit between KDHE and Sedgwick County. Look at the handouts: informs us of the transport mechanism. KDHE have purchased those and they are in located in Sedgwick County. IF there is a patient to be transported from facility A to B, the transport must be approved by KDHE. KDHE will contact MERGe duty officer. The team will consist of 7 people, 3 to transport, 2 for decontamination, and 2 for logistics. **Air transports? We have vast distances.** Only 2 aircraft in the U.S. that can transport this type of patient with equipment. They are both located in Georgia. MERGe and KDHE will coordinate with them to make sure the patient is transport appropriately.
- 15. Blood cultures, if collected, will KDHE take it?** If you suspect Ebola, or if they are considered a high risk after the screen do not take a culture. Limit the lab stuff, limiting laboratory testing to ideally point of care testing. Number of calls, you want to do a lot of testing, if they have a high risk history from the screening tool then you want to limit the amount of testing upfront. KHEL will not accept them; there is no need to get them.
- 16. Why are we using an N95 instead of surgical mask?** The first CDC recommendations only recommended standard droplet precautions and while those guidelines were in place, two nurses got infected. Now CDC is instructing PAPR and N95 even though Ebola is not respiratory, not transmitted through the air. There is a potential for aerosolizing procedures happening, that is why we made the recommendation to use the N95 respirators.
- 17. Info [the travel history from the airport] from KDHE sent to the LHD, can we share with everyone hospitals, other counties?** We could, the law does allow this information to be shared only with particular people, we need to balance the needs of the public with the rights of the individuals, and we would not send that to the family. Any information shared, should only be minimal protect the patient's rights.
- 18. Since Ebola is in semen is KDHE or CDC monitoring semen samples?** After a patient was treated in Africa, then he returned to India, his semen was tested and it contained Ebola. KDHE does not plan to test semen; we recommend abstinence or condoms for 3 months. Check and report Ebola care package: thermometer and self-monitoring information will be included, but not condoms.

- 19. If you get a patient in from the countries, the labs we are running that we send to the KDHE, is that to rule out Ebola?** The rule out test for Ebola is PCR. KDHE does not conduct the test for rule out. There are 15 LRN labs in the country that can do the rule out. NE is our closest LRN lab. NE and CDC will test; CDC must do the confirmation test. The facility will collect two specimens. KDHE will coach, one will be sent to LRN lab and the other will be sent the CDC for confirmation. Collect in EDTA tubes, purple tops.
- 20. Fort Hays student health, have they sat at any TTX? It has been discussed, how are we supposed to do it? How many have a thermometer?** They will give thermometers at the airport. Two contact names, phone numbers and emails. Lost to follow-up is minimized. CDC and airport people collect and it is provided to KDHE and how and when they will get in touch with them. Look at the most sensible way on how they are monitored. Look into their living situation. Go to the Board of Regents, they assure us they are having the conversation will continue to work on that.
- 21. After the local HD is notified, does that HD contact that person? Do they meet with them or how do they communicate twice a day?** We recommend having phone call, we can Facetime and other alternatives, who else is in home, LHD can get a better assessment, the main thing is no direct contact.
- 22. At school at State, swine flu, State got the memo, they sent home and had a special cleaning of the dorm room maybe a different site they can “live” maybe an avenue, they were very serious about swine flu. Sent in a crew to pack your stuff!** Flu is much more transmittable, separate living arrangement identified, Local HD need to consider alternate living arrangements. State of North Carolina put them up in a special place. HD and other agencies and who pays, how feasible and other things to consider.
- 23. If you have a community or a facility that identifies a high risk candidate, not only will that be exciting for staff, the local media will be excited, CNN excited, and CDC will be very interested, they will mobilize a response team, and so will KDHE, they will NOT take over, look at what is going on, look at the communication identifying resource needs. If KDHE thinks it is very important, you will be getting help, a lot of things will happen really quickly. How quickly ramp up the crisis communications and regional to state. Coordinate work and have the talking points identified and ready to go. Addressing information will be very critical. Will not be alone for long.**
- 24. Holiday season, I’m going to visit a relative that does not have symptoms, what does she need to do when she goes back to Hays?** Enjoy the holidays. Possible Ebola, only 4 diagnosed in the US, all the contact have been in the medical community. This is a nasty disease, highly virulent, no cure, high fatality rate, until we have time to work on public education and phase 2 and phase 3 vaccines, we have some time before this becomes an issue. We like to have the conversation to see the difference in the conversation.

Closing, Dr. Robert Moser

We have been around and talking at the variety of sizes, asking about TTX and there are some facilities that are hoping no one will come, and there are some that are getting ramped up to care for a patient until they can get transferred to a place like a bio-containment. We look at our health care system, we need to be looking at this type of disease using an all-hazards approach; identifying, isolating, stabilizing and then

transferring to the correct place, for us it will be NE. Hospitals may have to treat the patient for 4-7 days until confirmed, if they come in at day 3 and the Ebola sampling changes, if the NE test is negative, and the CDC test back comes back negative, the viral titer in the body needs to be higher to make a confirmation test, if the initial specimen is sent in then, we need to wait for 3 days longer. It will take a confirmed Ebola case before NE will take the transport, so they might be relatively ill, and we may have to transport by air. There has been a lot of involvement from KDHE and CDC. We do not want you to do shot gun medicine, you do not want to do all the testing, there are protocols that should be put in place to make sure other diseases are tested first. For Malaria, typhoid, do peripheral blood smear at the bed side. POC testing should be ideal. You may get electrolytes, hgb, cannot get white, or hematocrit, if you think you may have an Ebola patient and take it to the laboratory, as recommended by the ASM, and you run it through the chemlabs. We have heard NO company will work on the equipment after it has been tested the Ebola patient. You will void the warranty. Costs a lot to get POC equipment, but it might be cheaper than chemlab equipment

Crisis standards of care. Unfortunately we are caring for patients get ill quickly, we are stuck with what we are doing what we can. We can place the patient on a ventilator and give dialysis. But, really if you get to that point, that intervention is not successful, you cannot do everything for everyone, and your hospital may want to start considering Crisis standards of care. Mass casualty and resources are low so the standard of care lowers. Because this is one patient at the time then this isn't the necessarily a crisis of care instance.

Mike Tate, BOW

There is a legitimate solid waste management. One patient can generate a lot of drums of the stuff, 4-8 drums a day; however, this will not push your facility into a large generator. A lot of times you are doing this presumptively, then rule out not Ebola, then it isn't hazardous waste, obliterate the "hazardous waste" label, and handle it as normal medical waste.

Waste water, the city can tell you they will not take Ebola waste. KDHE has gotten letters out to every city with a hospital in their town. It is safe to let it be flushed, but do an extra step of disinfection 9 parts water 1 part bleach, to decrease the potential of exposure. CDC has put out interim guidance for waste water workers; they are silent about the bleach treatment in the toilet. Key thing, it is a VERY LOW RISK if you are in the waste water system. That goes for the city workers and the plumbers. The caveat is they need to use the appropriate PPE. Make sure they don't have an open cut or wound. If treated, the city should accept the waste. Work with them on the waste water and if it does need to go to the waste water. CDC has done a webcast about waste and suggested hospitals to purchase a camping toilet for the room and use the bags that come with that, and solidification material then put those bags in with the rest of the waste materials.

Last call for questions

Next update, we are having lots of conversations as we have gone around traveling the state. We would like to include in the next response plan, a walk through a "What if" to stimulate thought and concern to give some insight on how to approach things, not that we do it perfectly, just to stimulate discussion.

Remember to do the travel history at all areas of healthcare, even those on the periphery, like at the Dental Office. Anywhere a person seeking some kind of health care, Chiropractor, etc., if it has been within 21 days, if the patient has been to one of the four countries. Ensure they understand how to isolate and how to contact the right people to get the resources they need.

Thanks so much for allowing us to be out west. Please email response2014@kdheks.gov, or call Epi hotline, if it is not an emergency, try to use the email.