

NWX-DISEASE CONTROL & PREVENTI

Moderator: Thelma Williams

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1:30 pm CT

Note: We apologize for portions of the call that were difficult to hear due to audio technology. Corrected information appears below in brackets highlighted in red.

Coordinator: Welcome and thank you for standing by. At this time all participants are in listen-only mode. During the Q&A session if you would like to ask a question you may press Star then 1.

Today's conference is being recorded. If you have any objections you may disconnect at this time.

Now I'd like to turn your call over to your host Ms. Thelma Williams. Ms. Williams thank you. You may begin.

Thelma Williams: Good afternoon from Atlanta Georgia. My name is Thelma Williams from the Centers for Disease Control and Prevention Emergency Operations Center, and I would like to welcome you to today's Emergency Partners call for the Private Sector.

Our goal today is to address specific concerns that private sector organizations and businesses may have regarding the Ebola outbreak in West Africa.

We are fortunate to have some great subject matter experts with us today to provide information and updates.

First we will hear from Captain Jeff Nemhauser from CDC's Office of Public Health Preparedness and Response.

We'll also hear from Commander Lisa Delaney from CDC's National Institute for Occupational Safety and Health, Dr. Nicole, (Nicky) Cohen from the CDC's National Center for Emerging and Zoonotic Infectious Diseases and Rebecca, (Becky) Bitsko, PhD from the National Center on Birth Defects and Developmental Disabilities.

We will hear from all speakers before beginning the Q&A portion of the call. During that time we will take questions from callers and answer some of the questions we received via email.

We regret that we will not likely be able to get to all of your questions during this time but encourage you to visit CDC's Website www.cdc.gov to find the latest information about the current Ebola outbreak.

You may also contact CDC-INFO by email or phone with your questions. Media should call the CDC Press Office at 404-639-3286.

We will be sending a summary of the call via email as soon as it is available. Please feel free to forward this summary to others and email emergency_partners@cdc.gov if you do not receive a copy.

So let's begin. Captain Jeffrey Nemhauser is the Deputy Director of the Office of Science and Public Health Preparedness and Response.

Captain Nemhauser is also serving as the Deployment Risk Mitigation Unit Coordinator for CDC's Ebola response and he is a Captain in the US Public Health Service.

Captain Nemhauser will provide an update on the Ebola epidemic in West Africa, recent developments in the United States and answer questions addressing private sector concerns and support.

At this time I would like to turn the call over to Dr. Nemhauser.

Dr. Jeff Nemhauser: Hello and good afternoon from Atlanta, Georgia. I'd like to start out this afternoon by saying I've had my flu shot have you had yours? I'd like to encourage everybody to get their flu shot if they haven't had one.

The current status of the Ebola outbreak in Guinea, Sierra Leone and Liberia all three of those countries have been declared humanitarian disasters.

As of yesterday the total in West Africa is nearly 13,000 cases with a little more than 5000 deaths due to Ebola.

And the impact of that is fairly devastating. It's not only ruining individual lives but of course families have been disrupted, the economies of those countries has been [disrupted]. They are among already the most vulnerable [communities in the world].

So what is CDC doing? Well this is the largest international deployment in CDC s [history].

CDC is coordinating with the U.S. Government, Health Ministries of the affected countries, WHO, Médecins Sans Frontières (MSF) and other regional and international partners to provide epidemiologic, health communications and laboratory support to interrupt and mitigate the current Ebola virus transmission.

[We are working with currently unaffected countries surrounding the three outbreak countries.]

We do know that the risk for an outbreak in the United States [is very low]. And that's really I think given all the information that we [know about the] outbreak in West Africa as well as what we learned by what's happened in [Dallas and Ohio].

We know how to stop the spread of Ebola and [through case finding]. We [also know through isolation of ill people], and contact of people who have been exposed and I [believe these methods will work in the future] should another incident occur of someone coming in to the United States.

We really have at this point one person who is [in treatment] who came back from West Africa. His condition is stable. He is in the hospital. There is what's called active direct monitoring of three contacts of his.

Active direct contact monitoring rather implies that someone from the state's health departments actually visit those people on a daily basis, checks their temperature and lays eyes on them checking them for symptoms of disease.

The hospital personnel that are attending to this individual to the physician that's in New York, they're all being monitored and there the health department in New York is also very aware of with those individuals are.

There's also active monitoring of the emergency medical services staff who took care of him, the public health laboratory folks as well as people, other people who came into incidental contact with that individual.

They're undergoing what's called active monitoring which in contrast to direct active monitoring involves a call to the health department, or rather the health department calls them and again inquires as to their temperature which they have to check twice a day as well as any symptoms.

If they don't contact the health department then the health department does make direct contact with them should they not be able to reach them otherwise.

In Dallas as of a couple of days ago, 177 contacts of Mr. Duncan were traced. A hundred and thirty-three of those 177 have completed their surveillance and so they're all in the clear.

All of the health care workers who took care of him are being actively monitored. And at this point there are fewer than two days left of monitoring for everyone who came into contact with him. So we're nearly done with our contact tracing in Dallas.

And as of today all the monitoring of that was taking place in Ohio for the healthcare worker who traveled from Texas to Ohio has been completed. So Ohio is now no longer involved in active contact monitoring.

We've also sent several teams out to the field, what are called the Rapid Ebola Preparedness Teams. And these are people with expertise who are looking and the helping hospitals that have been identified as candidate recipients for regional - as regional Ebola centers.

So we have these teams that have gone out and that are helping these hospitals get ready should a patient come to their hospital.

We have people in Pennsylvania, in Georgia and eight other states or jurisdictions that have gone through the assessments.

And at this point in time I think another three states are slated. But we've got - we're developing a cohort of and a network of hospitals across the country that should not be surprised, should not be caught unawares if a patient comes to their hospital so that they can deliver appropriate treatment.

Yesterday it was announced that the White House is seeking a little more than \$6 billion, 6. - close to \$6.2 billion through an emergency funding request to Congress.

And CDC itself has requested \$1.8 billion of that in funding to help prevent, detect and respond to the Ebola epidemic.

That money will go to a wide variety of programs and activities including strengthening our domestic public health systems in advancing US preparedness to improve Ebola readiness within state and local health departments.

It will go towards the purchase of additional personal protective equipment that will be stockpiled with the strategic national stockpile part of the Centers

for Disease Control and Prevention's efforts towards emergency preparedness and response.

It's also going to go to doing support for monitoring of travelers at the US airports. As I said CDC is staffing the quarantine stations at airports several airports across the country into which individuals who are traveling into the United States from West Africa that they're traveling. And we're doing a very diligent job of identifying those people are and tracking them.

It's also going to go towards helping to control the epidemic in the countries in West Africa. We have folks in West Africa who are doing infection control, contact tracing, laboratory surveillance and training. And we're also setting up emergency operations centers in those countries.

It will also help us to establish global health security capacity in vulnerable countries so that in countries where there isn't a - as robust a public health system as there is in the Western world the CDC is trying to help those countries by developing systems and putting in infrastructure that will allow them to more rapidly identify, detect and control outbreaks.

So those are some of the activities that the CDC is currently engaged in. And that is current asked by the CDC of the White House for additional funding in order to help get the current Ebola outbreak under control.

Thelma Williams: Thank you Dr. Nemhauser. I would now like to introduce Commander Lisa Delaney. She currently serves as the Associate Director for Emergency Preparedness and Response at the National Institute for Occupational Safety and Health where she promotes research in the area of protecting first responders during emergencies, ensures federal response plans incorporate

occupational safety and health protection measures and coordinates NIOSH's response to emergencies.

Commander Delaney has specialized in biological emergency responses with a focus on understanding the role, the environment plays in disease transmission and protecting workers during their responses.

She is responding to the current Ebola outbreak by serving as the Worker Health and Safety Team Lead within CDC's Emergency Operation Center.

This team is providing Personal Protective Equipment expertise on appropriate selection and use of PPE for all worker; conducting heat stress and comfort measurements to assess impact of wearing PPE, and providing recommendations on ways to protect CDC and other deployed staff.

Commander Delaney will discuss recommendations for businesses to protect their employees from potential exposure to Ebola virus disease, (Ebola) in the US and while working overseas. I would now like to turn the call over to Commander Delaney.

Lisa Delaney: Hi, good afternoon. I'd like to start off with just reminding people that the current risk of Ebola exposure in the US is very low in non-healthcare workplaces and that most US employees are not likely to encounter Ebola or people infected with Ebola.

And it's a really critical message to give especially in light of all the fear and that people have and rightly so of potential exposures.

However there are certain occupational groups that have - that do have a higher risk of exposure to Ebola. And CDC has worked to develop specific

guidance for groups such as healthcare workers, laboratorians, airline personnel and other first responders.

And while that information can be found on CDC's website we've also created an Ebola topic page on the NIOSH Website which nicely pulls out and highlights the occupational related guidance that's been developed by CDC.

And we have a few additional links to the Occupational Safety and Health OSHA's Ebola website as well. So that could be a good resource for participants.

We're also working on guidance, general business guidance for non-healthcare settings. And that's currently in clearance at CDC so that will be posted on the CDC website and the NIOSH website as soon as it's cleared.

In terms of general recommendations we recommend that businesses consider developing and starting an Ebola communication plan and providing employees with accurate and reliable information about Ebola.

Education is really critical and reminding employees that the risk is very low of contracting Ebola here in the United States.

Dr. Cohen will follow on my presentation and provide great information about the public health monitoring procedures that are in place for returning travelers and other people here who may have come into contact with Ebola cases.

And so again I think that that's an important message to share. It's a reassuring message to share with employees.

We encourage employees to continue the good hand hygiene and other routine infection control precautions. It's especially important as we move into the cold and flu season.

And I certainly appreciated Captain Nemhauser's reminder of influenza, getting the influenza vaccination.

And we also recommend, just as we would recommend under routine circumstances that employees do not handle or touch objects with blood or body fluids. And that follows with the OSHA's blood-borne pathogen standard that to avoid anything that may contain or appear to contain blood or body fluids.

We also recommend that you consider developing a plan to manage in the unlikely scenario that employee or a customer with an exposure history of Ebola that they should develop an Ebola symptoms that you have a plan for how to handle that and then you train employees on the plan.

So in terms of work overseas CDC recommends avoiding nonessential travel. And we have an excellent travelers' health website that you can visit to learn more about our travel recommendations.

So we recommend postponing employee travel to areas affected by widespread Ebola and consider alternative ways of doing business.

If you must travel to an Ebola outbreak area businesses should again check that CDC travel health notices page for latest guidance and recommendations.

We also recommend that you develop plans and examine policies for employees traveling to those countries if you decide to send employees over

and that you should include medical care and evacuation plans as part of that before you send employees to those countries.

So it's really important that you find out about the health and evacuation insurance coverage and that you plan for medical care evacuation for employees during their trip.

And we also recommend that employees before traveling to visit their travel health specialist so they can get up to date information and vaccines and medications before they travel.

And again I just want to remind that to become aware of the public health monitoring of returning travelers that Dr. Cohen will go into more detail on I think is a very critical message, a reassuring message so the colleagues can feel safe about returning colleagues who may have been traveling to those countries.

So in terms of returning employees we recommend that those employees should follow the public health actions and messages that they're getting when they return to the country.

And we also, recommend that they would continue to - that the guidance that would be given to them may have additional restrictions for work or travel, public conveyances or congregate gatherings.

And that'll be dependent on the assessment that's made when they return to the country. So recognize that it may include restrictions for work. And that'll again be discussed in more detail.

In terms of recommendations for employers and employees can consider provide a more flexible work arrangements such as tele-working from home if that's an option for some returning employees who are being monitored.

We also recommend that you provide returning employees with mental health counseling. This is particularly important for some who may be returning from humanity - humanitarian aid mission to assist with their transition back into the US.

Again it's also critical that education piece educating supervisors and coworkers that the risk is very low for getting an Ebola infection in the workplace from workers that are returning from countries with Ebola outbreaks especially if they don't have the signs or symptoms of Ebola.

And it's important not to stigmatize staff who are returning from West Africa.

Again we also recommend that you make sure your business has continuity plans so if there's operation can continue even if some key staff members are unavailable to work. So that concludes my presentation.

Thelma Williams: Thank you Commander Delaney. I would know like to introduce Nicole (Nicky) Cohen, MD MS, she is an Infectious Disease Specialist and the science lead for CDC's Global Migration Task Force on this Ebola response.

She works as the Associate Chief for Science with CDC's Quarantine and Border Health Services Branch.

Dr. Cohen will provide an overview of CDC's updates to the interim Ebola monitoring and movement guidance.

She will also cover travel and border health-related topics such as exit screening in countries with widespread Ebola virus transmission and enhanced entry screening for travelers from these countries at US airports.

I would now like to turn the call over to Dr. Cohen.

Dr. Nicole Cohen: Thank you. And thank you all for joining us this afternoon. First I'd like to mention that for CDC and others in the US government as well as all of our partners stopping Ebola is both a public health and a national security priority.

We at CDC are working together with many countries and organizations to bring up the Ebola outbreak in West Africa under control because there is no way to get to zero risk in the United States until we are able to stop Ebola at the source.

CDC developed the Monitoring and Movement guidance as part of a risk-based layered strategy to help prevent the spread of Ebola into the United States through travel related importation.

The layered strategy includes exit screening for travelers leaving Guinea, Liberia, and Sierra Leone. And this is one of the most effective measures to control the outbreak from spreading, enhanced entry screening at five airports where all travelers from these countries are currently arriving, post arrival monitoring for 21 days after leaving the affected country and movement or travel restrictions for these people based on their exposure risk.

When developing guidance for public health actions CDC aims for the least restrictive measures to protect the public's health.

The monitoring and moving guidelines are based on rigorously collected scientific data and over 40 years of experience with Ebola affection and how it spreads to others.

For example, we know that Ebola does not spread easily like measles, the flu or the common cold.

Transmission requires direct contact with blood or body fluids of a person sick with Ebola and people are not infectious until they develop symptoms.

As Dr. Nemhauser mentioned , we have had four cases diagnosed in this country and there has not been widespread transmission of Ebola in the United States.

In fact the group of almost 50 people who were exposed to the first person with Ebola in Texas before he was hospitalized as mentioned have finished their 21 day monitoring and were cleared to return to the regular activities. And there were no further transmissions beyond the two healthcare workers that cared for this patient in Texas.

So as you may be aware on October 27 CDC updated its guidance on monitoring and movement of people and potential Ebola virus exposure.

In this guidance we referenced updated definitions for how we classified exposures, and recommendations for how people in the different category should be monitored and when additional actions such as movement restrictions may be needed.

The guidance defines four classifications -- high risk, some risk, low (but not zero) risk and no identifiable risk.

Most travelers from the three countries with widespread transmission will fall into low risk category. This is actually the lowest category that a person who has been in one of these countries within the past 21 days can be in.

Other people in this category include people who traveled on an airplane with a person who is symptomatic with Ebola.

And for all people in this category we are recommending active monitoring by a public health authority which could be something like a daily phone call with the health department.

In addition the person takes his or her temperature twice a day, watches for symptoms such as fatigue, headache or muscle aches and notifies the health department if symptoms develop.

Active monitoring continues until 21 days after the person left the outbreak country or the last possible exposure to Ebola.

The purpose of active monitoring is to ensure that the person is closely followed by public health authorities so that if symptoms develop actions can be taken immediately to separate the person from others and arrange for medical evaluation.

In the low risk group we are not recommending any additional restrictions beyond the active monitoring.

People in the some risk category are mostly healthcare workers who treated Ebola patients in one of the countries where the outbreak is occurring.

For these people we are recommending what we call direct active monitoring, which includes direct observation as part of active monitoring as an additional layer of precaution.

For this group of people health departments may choose to impose additional restrictions based on an individualized assessment of the person's situation.

However, CDC recommends that these people travel back to the United States and be allowed to continue to their final destination.

In the high risk category are people who have had direct exposure to the blood or body fluids of an Ebola patient, such as through a needle stick or a household member who took care of a person with Ebola in the home.

We actually recommend that these people not travel at all until 21 days after the high risk exposure, including traveling back to the United States, unless the travel occurs by private chartered plane or private vehicle.

The reason for this is to avoid the possibility that these people could develop symptoms during travel and risk exposing others for example on a plane.

If these people arrive in the United States, they will not be allowed to travel further by commercial conveyances, and additional restrictions such as staying away from busy public places, are also recommended.

The last category which is called "no identifiable risk" includes people who might be thought to be of concern for Ebola exposure but who actually don't have any exposure.

These could be people who were in outbreak country more than 21 days ago, or a family member, such as a child of a person who is in a country with Ebola or even a person who had been in a country where there have been of few Ebola cases, but no widespread Ebola transmission such as Spain or other parts of Africa.

There are no monitoring or movement restrictions recommended for this group. However we have found that with significant and understandable fears surrounding Ebola that there have been situations where people have been inappropriately restricted for example from schools, workplaces, churches, et cetera, because of the lack of understanding of a person's risk of having or being able to spread Ebola.

That is why we found it necessary to emphasize when it is not appropriate to apply burdensome restrictions or monitoring when a person does not have a risk of exposure.

I would like to very briefly touch on two of the other mechanisms that we're using to reduce the risk of Ebola entering the United States.

As I mentioned exit screening is happening for all travelers leaving Guinea, Liberia and Sierra Leone where travelers undergo a process that includes screening for symptoms including a questionnaire for - to ask people if they have symptoms, a temperature check and asking them whether they have been exposed to Ebola.

The process happens a little differently in each country, but does include all of these elements.

Travelers with symptoms at the time of travel or have been exposed in the last 21 days are asked to delay their travel until it is safe for them to travel.

Since airport screening was fully implemented, almost 90 people have been denied boarding and no symptomatic Ebola cases have boarded an international flight from these countries.

I also mentioned that since mid-October we have added enhanced entry screening at five US international airports as an extra layer of prevention and an opportunity to educate and support returning travelers with the potential risk of Ebola exposure.

Travelers whose trips originated in Guinea, Liberia or Sierra Leone are asked about symptoms and possible exposures and have their temperatures checked again.

Each traveler gets a kit called a CARE Kit , which stands for “Check And Report Ebola.” The kit includes educational materials about how to monitor for Ebola symptoms, and how to get healthcare if they get sick.

The kit also contains a thermometer to help the person monitor their temperature. If any travelers are sick upon arrival or report possible exposures to Ebola, CDC will work directly with the state or local health department to have the person medically evaluated or to arrange for monitoring.

CDC is also providing contact information of all screened travelers to the health department in their destination state to facilitate the recommended monitoring.

That is the end of my presentation. Thank you.

Thelma Williams: Thank you Dr. Cohen. I would now like to introduce Rebecca, (Becky) Bitsko, PhD, who's currently a Health Scientist at the CDC where she works on children's mental health and neurobehavioral disorders including Tourette's Syndrome and ADHD.

(Becky) is the Vice Chair of the CDC Mental Health Workgroup and works as part of the Mental Health Task Force in the CDC EOC.

Dr. Bitsko received her PhD in Neuroscience from Emory University where she also completed postdoctoral work in child development and also completed the Epidemic Intelligence Service, EIS Fellowship at CDC.

Dr. Bitsko will provide a brief update on stigma related to Ebola in the US, and some strategies they can help reduce stigma.

I would now like to turn the call over to Dr. Bitsko.

Dr. Rebecca Bitsko: Thank you. Stigma can occur because of a lack of knowledge about how Ebola is spread, a need to blame someone about Ebola, gossip that spreads rumors, myths, and fears about Ebola, and fear of about disease and death.

We've seen in history in many instances of societies excluding, blaming or devaluing those feared to have a disease, for example during the SARS epidemic and with HIV early on.

And in many instances the discriminatory actions caused the health problem to worsen because those who felt stigmatized avoided seeking access to the health care and information that they needed.

Some examples of stigma include making negative comments in the media about groups of people and Ebola, denying someone from West Africa entry to school or work because of Ebola fears, and avoiding or shunning friends or coworkers who have recently returned from West Africa including taking measures that are more than what are necessary to protect health.

And a number of strategies that can be used to help reduce stigma, first in the health care settings maintaining the privacy and confidentiality of those seeking health care and those who may be part of any contact investigations; communicating early the risk or lack of risk from associations with products, people and places; sharing accurate information about how the virus spreads; explaining that Ebola is caused by a virus and not a person; speaking out against negative behaviors including negative social media statements about groups of people or exclusion of people who pose no risk from regular activities.

Be cautious about the images that are shared. Make sure they do not reinforce stereotypes.

Engaged - engage with stigmatized groups and persons and through media channels including news media and social media.

And share the need for social support for people who have returned from the region who are worried about friends or relatives in the affected regions.

Thank you.

Thelma Williams: Thank you Dr. Bitsko. We will now move into the question and answer portion of today's call. We will alternate questions from the phone with those submitted via email before the call.

Operator if you would please open the lines for questions. But before we go to our first question, I would like to mention that there are many resources you may find helpful on the CDC Ebola website. The address is www.cdc.gov/ebola.

I would also like to mention we are fortunate to have several colleagues on the call from the CDC At -Risk and CDC Mental Health teams actively involved in the Ebola efforts who are also on the call as well and will be present to respond to any questions.

They include (Commander Maleeka Glover), the At Risk Lead with the At-Risk/Vulnerable Populations Group and (Meghan Fry) with the Mental Health team who will also be available.

The first question is for Lisa Delaney. To date, high level guidance has been provided from the CDC related to environmental hygiene when caring for patients with Ebola in the United States. Can you elaborate a little bit more on that issue?

Lisa Delaney: Yes sure. On October 20 CDC released guidance titled “Guidance on Personal Protective Equipment” to be used by healthcare workers during management of patients with Ebola virus disease in US hospitals including procedures for putting on donning and removing doffing.

And in this guidance we talk specifically about cleaning recommendations while treating patients.

We discourage including additional staff to go into the patient room for cleaning with the traditional environmental services staff and recommend that the nurse or clinician that are in there treating the patient continue to disinfect

the environment immediately if there's any visible contamination on PPE, other equipment, patient care services with an EPA registered disinfectant wipe.

And then we recommend just performing regular cleaning and disinfection of the patient care area, even in the absence of visible contamination.

So, if you want to get more information you can review that document that's available online.

Coordinator: And excuse me at this time would you like me to give the instructions on how to ask a question?

Thelma Williams: Yes. Can you please do so?

Coordinator: Thank you. At this time if you would like to ask a question please press Star 1 on your touch-tone phone. You will be prompted to record your name.

If for any reason you'd like to withdraw your question you may press Star than 2. Once again if you like to ask a question you may press Star 1 and record your name. One moment for the first question.

Thank you. And that first question comes from (Fredette West). Your line is now open.

(Fredette West): Thank you. And thank you for the updates you've given us. With regarding to the status where is the US in setting up emergency medical facilities in West Africa, how many have been set up, the number of patients being treated, to what extent are patients having being - having to be turned away -- that type of thing.

And within that 6.18 billion does that include funding for Defense Department what they're doing in terms of Ebola? And also does it include direct funding to West Africa? Can you hear me?

Thelma Williams: I'm sorry. I'm trying to catch - there were so many different pieces to it. You wanted to know the status of the US and setting up...

(Fredette West): The emergency medical facility.

Thelma Williams: ...emergency medical facilities in Africa?

(Fredette West): Yes and the number of patients being treated and to what extent are we having to turn away patients?

And then with regard to that 6 billion that's being requested does that include direct funding for DOD Ebola operations and any direct funding to West Africa itself?

Dr. Jeff Nemhauser: With regard to whether or not, you know, what that represents in terms of the Department of Defense funding I'm not really aware of what the DOD has requested so I can't respond directly to that.

Although I do know that the Department of Defense has been instrumental in going in helping to set up a treatment facility in Africa.

(Fredette West): Yes.

Dr. Jeff Nemhauser: The facility that's being set up there , and I believe is nearly ready to be opened if it isn't opened already is designed specifically to provide care for healthcare providers who are themselves at risk for getting disease.

We know it's approximately 10% of healthcare providers in Africa that are delivering care are themselves becoming victims of Ebola.

And there was a need there to establish a facility so that people who were sending their staff into country could be reasonably insured that the healthcare providers themselves would have somewhere to go in the event that they became sick.

And so the Department of Defense was instrumental in helping to build a facility in Monrovia. And that facility is being staffed by our United States Public health service officers.

(Fredette West): So that's only for the US and non-US medical staff because that's not for West African population and patients?

Dr. Jeff Nemhauser: No. No that's for any healthcare provider that is in Africa. So that is not in fact specifically for United States. That's for any healthcare provider that is there.

And that can be a laboratory worker, that could be somebody who's...

(Fredette West): Okay.

Dr. Jeff Nemhauser: ...assisting with the burials, the proper burials and funerals, people who may be doing cleanup work in the hospitals.

(Fredette West): I understand.

Dr. Jeff Nemhauser: So it's really there as a means of encouraging people to send additional staff to really combat Ebola in West Africa.

(Fredette West): So our greatest void now is actually having medical facilities for Africans themselves that are non-medical related?

Dr. Jeff

Nemhauser: Well we know that there are increasingly the number of beds that are available to receive patients in West Africa that the number of beds continues to increase primarily because many of the instances where we have Ebola now it's moving more out into the rural into the country areas where there may be fewer treatment centers.

And so there's really a focus now on trying to ensure that the people that are in the more rural areas have an opportunity to get the kind of care that they need.

But in terms of the cities, the numbers and the figures that we're seeing indicate that there is quite a good availability of beds for those people so that we can get people into those centers and get them the care that they need.

Lisa Delaney: I think it's important to point out that CDC we do not provide direct clinical care. That's not our role in deploying and working in West Africa.

But that's other groups within the federal government are providing that resource and that service in West Africa.

(Fredette West): Do we know if there's still dead bodies in homes?

Thelma Williams: Excuse me. I want to move on Ms. (West) but I do want to cut you off...

(Fredette West): I understand you want to move on. I can understand that.

Thelma Williams: But can you - what I would like to know if you can possibly forward that question to the Emergency Partners Mailbox, the second part. I would definitely want to give you a response to that but I definitely have to move on, my apologies.

(Fredette West): Okay. I'll send it in hopefully for a response.

Thelma Williams: And I will be sure you get a response.

(Fredette West): Okay.

Thelma Williams: And you can attention it to myself. Thank you.

The second question I would like to present is to (Maleeka) - (Maleeka Glover). Is there any evidence the virus might be spread airborne and not require actual physical contact?

How long can the virus survive away from a host on a surface? Are any domesticated animals able to carry and not contract?

Dr. (Maleeka Glover): Yes. There is no evidence that demonstrates that the virus is airborne. And for Ebola virus to be transmitted it needs to happen through direct contact with blood or body fluids or substances -- urine, feces, vomit or with an infected person who is symptomatic or through exposure to an object such as

a needle that has been contaminated with the infected person's blood or body fluids.

As far as how long it can live outside the host Ebola can survive for a short period of time on surfaces typically not longer than 24 hours. But I mean of course it's also depending upon heat and a number of other things.

But if there are visible body fluids on a surface we would recommend avoiding those because it can be transmitted again through blood and body fluids of an infected person who is symptomatic.

As far as the question with regard to the animal host there is no evidence - I'm sorry I'm trying to - so at this time we don't have any reports of dogs or cats that have become sick with Ebola, or have been able to spread Ebola to people or other animals.

So even in the areas in Africa where Ebola is present there have been no reports of dogs and cats becoming sick with Ebola.

There is limited evidence that dogs can become infected with Ebola virus but there is no evidence that they can develop disease.

Thelma Williams: Is that the last response Dr. (Glover)?

Dr. (Malika Glover): Yes.

Thelma Williams: Thank you. Operator can you please open the lines for another question please?

Coordinator: Absolutely. The next question comes from Mr. (Paul Hodgkins). Your line is open.

(Paul Hodgkins): Thank you. I wonder if anyone on the team could explain the steps that you would expect an employer to take in the event that they have a possible or a probable case of Ebola that appears in the work place particularly those workplaces that may have some limited clinical services and healthcare personnel?

Lisa Delaney: So we would recommend that you follow the guidance as was outlined by Dr. Cohen in terms of how - what any limitations or restrictions would be placed on that employee, whether they could come to work or be in public gatherings and make those accommodations.

But the - again we talk about developing a plan. If you do have someone who is showing symptoms you may talk - or you can talk to them about not coming into work and they would already have that guidance.

That would be given to them as part of that when they enter the country, have that CARE Kit. That would have instructions on how to let local public health and notify healthcare if they're exhibiting signs or symptoms.

(Paul Hodgkins): So if they are in the workplace and that's where you discover it I presume isolate them in a room, contact public health. Should the employer attempt any preliminary contact tracing before public health arrive?

Lisa Delaney: So you may want to contain - collect a list of people who have come into contact with that person if they were exhibiting signs or symptoms.

And again that would depend on - part of the concern would also depend on the types of symptoms that that employee was exhibiting.

So signs like for has a temperature or just generally feeling bad would be much more less of a concern than if, you know, someone became ill, vomiting or diarrhea.

And in that case we would recommend that you isolate the area that if there was contamination that you would isolate that area and not allow - and then consult with public health in terms of how to respond and cleanup that area.

(Paul Hodgkins): Okay. Thank you.

Thelma Williams: Thank you Mr. (Hodgkins). The next question will be for Dr. (Nicky) Cohen regarding the latest M&E I'm sorry M&M guidelines. One part does not appear to make sense medically.

The idea that the risk to health care workers wearing PPE and caring for Ebola patients is different based on the country where the care is delivered.

Given that the risk of exposure is based on the patient provider interaction and protections why does CDC draw a distinction?

Dr. Nicole Cohen: Thank you. That's an excellent question. The decision to place healthcare workers who take care of Ebola patients in countries with widespread transmission into the some risk category was largely based on the recognition that healthcare workers in those categories have been infected in relatively high proportions, as Dr. Nemhauser mentioned up to 10% of healthcare workers.

We realize that some of these infections may have been unrelated to the Ebola treatment unit, for example community exposures.

However we believe that there are greater opportunities for unrecognized exposures in hospitals in affected countries including infection control breaches, problems with decontamination, for example inadequate concentrations of disinfectant solution, or encounters with Ebola patients in other areas of the hospital such as triage areas where staff may not be wearing their full PPE.

Therefore we feel that this group of workers warrants closer monitoring after they arrive in the United States.

Thelma Williams: Thank you Dr. Cohen. Can we have another call from the operator please?

Coordinator: Absolutely. The next question comes from Dr. (Henriquez). Your line is now open.

(Henriquez): Yes patient who is flying in an airplane are they in any danger if they are not in contact directly with a patient who is flying in one of the seats with Ebola?

Dr. Nicole Cohen: Hi. This is (Nicky) Cohen again. So our protocols consider people on an airplane who sat within 3 feet of the infected person or anybody who had direct contact with the affected person to be at - both be potentially at risk.

However in an abundance of caution we are also recommending that people elsewhere on the plane who may have possibly had an unrecognized exposure to the sick person or the person's body fluids for example, if the person had vomited in the plane, should also be monitored. However we are not recommending any restrictions for these individuals.

Thelma Williams: Thank you Dr. Cohen. Lisa this is for you.

What level of protection is required for airport employees tasked with removing human waste from incoming international flights of countries that have a confirmed Ebola outbreak?

Additionally would employees that service and maintain equipment used to remove this waste need any specific protection?

Lisa Delaney: Yes, thank you for the question. Again I think as was described by Dr. Cohen that the screening process that the likelihood of someone being on a flight who has Ebola and these severe symptoms of Ebola that would have contaminated waste is very unlikely because of the excellent screening process that's in place.

However we are working on guidance for sewage workers. So people would come in contact with raw sewage as part of their job before it enters the waste water center treatment facility. And that guidance is forthcoming and will be posted to the CDC Website.

But in general we - recommendations that we would recommend would include goggles and a face shield. If there is a potential depending on the type of task for an aerosol to be generated, an N95 would be appropriate, an N95 respirator. If not, then a surgical facemask and then rubber gloves or with an inner nitrile glove or other type of glove and protective clothing such as coveralls if there's a potential for splash.

Woman: Hi. We have a question about pharmacies and pharmacy chains. If somebody comes in presenting symptoms that - and they say that they've been to one of

these countries or that sort of thing maybe it's a pharmacy that has an on-site clinic with a nurse practitioner what should the procedures be for those that, you know, deal with sick people or people who could present, you know, in these small clinics within pharmacies or asking for over the counter medications? What do you think that they should do?

Dr. Jeff Nemhauser: I think it's important to recognize again that people who are entering into this country from the Ebola affected countries in West Africa are being carefully monitored.

They're identified as they come off of the plane and they enter through the ports of entry or the airports of entry into the United States.

And then communication goes from the individuals at the airport to their state health departments and that the risk of Ebola for these individuals is quickly identified and they're stratified into a variety of different risk categories from high to low.

And the folks that are in the highest risk categories are essentially put into a situation where their movements are somewhat restricted. They have to be directly observed twice a day in the event that they develop a temperature or symptom.

And then they're quickly isolated and kept away should they become symptomatic and put into an appropriate healthcare facility.

For the individuals who are in the low risk categories they in turn are also being tracked and monitored on a daily basis for 21 days.

And in the event that they should become symptomatic at some point over the course of those 21 days that would be rapidly identified by the state health department and again they would be put into a proper healthcare situation.

And should they become symptomatic at some point along the line it would be very early on in the disease when we know that the risk of transmission is extremely low.

Going back to the situation in Dallas where Dr. Cohen mentioned that individual was surrounded by a lot of people for a long time when he was sick and none of those people have subsequently developed disease.

So the risk of transmission really is quite low for those individuals. And they are being very closely tracked and monitored.

So I think although there is a concern and there's a fear there I also think that the systems are in place to quickly identify these people should they become ill and get them into the proper healthcare facilities where they can be kept away from others and receive the treatment that they need.

Lisa Delaney: And I would add that probably the closest guidance that we've issued at CDC that would fit that kind of scenario is guidance on identify, isolate and inform in ambulatory care settings.

And really that is to isolate the person and get EMS if there's a concern. So I would direct people to that guidance on the Web.

Thelma Williams: Thank you Commander Delaney. Operator we'd like to take our last call from the audience if you can open the line and give us the last - I'm sorry the last question please.

Coordinator: Sure. The last question comes from (Karen Kuno). Your line is now open.
And if you can check the mute on your line.

(Karen Kuno): Hello. Can you hear me? Are you able to hear me?

Thelma Williams: Yes. We can hear you.

(Karen Kuno): Okay good. My question is regarding the method of transmission. I've been educating our people and trying to reassure them of the very low risk and especially with airline travel since a large majority of our population has to travel frequently though not to areas of West Africa. They do travel a lot and they're very concerned to the extent that some are hesitant to get on an airplane.

So in trying to reassure them I've explained the method of transition or transmission. And I've described how direct contact takes place to try to reassure them.

And, you know, they're - where they're feeling very unsure is that the message that they appear to be getting though much of it is coming the media, you know, the media uses CDC as a resource.

And the message that they feel like it is being sent is that whenever there is any question about a potential infection they're seeing pictures of healthcare workers suiting up in their words like astronauts.

And they're questioning well why are they being put into isolation with separate ventilation and respiratory precautions if this is not a droplet contact and not an airborne contact?

And frankly it's difficult to answer those kinds of questions because it seems like there's a contradiction in what they're being told and what they're seeing. And I wondered how you would respond to that?

Lisa Delaney: This is Lisa. And I can speak sort of on two levels. A lot of the visuals that we're seeing from West Africa where people are really, the healthcare workers and others are providing care are in full personal protective equipment and you see them being sprayed down with disinfectant.

The care scenario in Africa is very different. In some places running water isn't even available to these healthcare workers so some of the very basic infection control practices are not available. And so it calls for this much higher level of Personal Protective Equipment. And we're all seeing the news footage and it does raise concern.

Here domestically we have healthcare settings that allow us to care for patients in a much safer environment. However we did modify the guidance to include higher levels of protection based on our experience with the Texas case.

And we also - once that patient is identified as having Ebola they are placed in a room, a single patient room with a dedicated bathroom. That's the recommendation.

And we are also recommending the full skin coverage. And part of that has to do with concerns that we have of the donning and doffing.

I mean the symptoms of patients with Ebola are very unique where there are - is a lot - a great high potential for exposures to body fluids.

And then that when the PPE becomes contaminated it can be - you can self contaminate during the donning and doffing process. And so that's another reason that we want to have the high level of PPE so that it can be removed in a careful manner.

We also go to the recommendation for a respiratory protection because while it's not a traditional airborne transmitted disease like you think of with smallpox or tuberculosis there may be certain medical procedures, intubation and other types of medical procedures that could potentially generate an aerosol that could become airborne the contains the virus.

And we can't always anticipate or predict when those types of procedures are going to be needed.

So rather than have the healthcare worker leave the room and then come back we're just trying to create a more efficient process for providing that, the appropriate PPE in anticipation of these aerosol generating procedures that that would provide the respiratory protection.

Thelma Williams: Thank you commander Delaney. One last final comment?

Dr. Nicole Cohen: Yes, hi. This is (Nicky) Cohen. So just to address the question about transmission on airplanes and I know we had an earlier question about who is at risk which I did answer.

But I would like to remind our audience that traveling on airplanes is considered to be an extremely low risk for getting Ebola.

First of all there have been instances where people with Ebola did travel on airplanes including one of the healthcare workers who became infected in Dallas who traveled on two airplanes in the United States and a recent instance where a person traveled from Liberia to Nigeria.

And in none of those situations did we find any cases of Ebola in any passengers or crew or cleaning crew from those aircraft in the 21 days after the flights.

And we did look for them. We, you know, we monitored all of those people for the US flights and Nigeria monitored people for their flights. And there were no - there was no evidence of transmission.

People on planes generally don't have the kinds of interactions that would result in exposure to another person's body fluids.

And it's also very important to remember that even if people are sick on airplanes most of those people will have, you know, very common diseases such as flu or stomach viruses. And, you know, it's extremely rare that somebody with Ebola would even be on a plane.

I think that's probably enough. Thanks.

Thelma Williams: Thank you. I'd like to say a special thank you to all of our speakers for sharing this valuable and timely information, and thank you to our participants for joining us today.

We will send a summary of this call to participants as soon as it is made available. For those of you who submitted questions via email that we were

unable to get to, we have routed those questions to the appropriate subject matter experts for responses.

If you have additional questions you can email them to cdcinfo@cdc.gov or call 1-800-CDC-INFO.

Due to the high volume of inquiries, there may be a delay in response. And don't forget there is lots of information on our website www.cdc.gov/ebola.

Thanks again for your interest and engagement in this important topic. Operator this concludes our call for today. Thank you.

Coordinator: Thank you all for joining today's conference. All participants may disconnect at this time.

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