

NWX-DISEASE CONTROL & PREVENTI (US)

Moderator: Kellee Waters
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Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. After the presentation we will conduct a question and answer session. If you would like to ask a question you may press star 1. Today's conference is being recorded. If you have any objections you may disconnect at this time.

Your host for today's call is Dr. Benjamin. Thank you, you may begin.

Georges Benjamin: Hi, good afternoon, everyone. This is Georges Benjamin and I'm the Executive Director here at the American Public Health Association. And I want to welcome you to the American Public Health Association's briefing on Ebola.

Obviously Ebola has become a very important outbreak certainly to the people of West Africa but also to the people of the world. The United States as a nation has been very involved in this outbreak and many of our members I think have heroically been involved in going overseas and trying to help stem this infection.

We thought it would be important that we gave you an opportunity today to get an update on the Ebola outbreak in West Africa and what the US Center for Disease Control and Prevention is doing about that. Talking a bit about health worker protections and protocol and safety measures in the United States and also how can APHA members help getting involved in educating the public.

With us today are Dr. Clive Brown, who's a medical epidemiologist with the Division of Global Migration and Quarantine; Dr. Joe Perz who's an epidemiologist with the CDC Division of Healthcare Quality and Promotion; and Leeanna Allen who is a Health Communication Specialist who's working on Ebola domestic partner outreach.

The way we want to conduct this today is allow those three professionals to speak and get some questions and answers from you. And we have, at the most until 3:00 pm today to do that. But we'll go until, you know, we've gotten a chance to answer all the important questions that you may have.

And with that - I'm going to turn it over to Dr. Brown. Dr. Brown.

Clive Brown: Thank you, Dr. Benjamin. Good afternoon, everyone and thanks to APHA for organizing this session. So I'm going to speak mainly today about the guidance that we published on this Monday, the monitor and movement guidance for people with Ebola.

As everyone I'm sure is aware, stopping Ebola is a public health but also a national security priority. There are many countries and organizations, including CDC, the World Health Organization, who are working to bring the Ebola outbreak under control in the three most affected countries.

So to help in that process CDC released what we're calling a Monitor and Movement guidance to help prevent the spread of Ebola in the United States. It is based on the most rigorous scientific evidence available based on 40 years of experience in dealing with the disease.

I want to lay out first just a few other points in that this is really the part of what we're calling a layered strategy working of course in the countries with teams that are helping to do contact investigations and limit the spread within the countries.

Our particular division, the Division of Global Migration and Quarantine, is working with airport authorities and the administrators of health in these countries to also fulfill the WHO mandate of limiting the condition within the disease by implementing screening processes at airports.

So the charge includes starting a system that - what we're calling exit screening - that is everyone who is leaving those three most affected countries are screened for symptoms, exposures, a visual check and their temperature before they can depart the country. And anybody who screens positive on any of those things are denied exit.

We also are working with our airline partners and those airline partners assist in two ways; one if somebody somehow passes the screening process they - but the airline notices somebody who looks ill, they have the authority to deny boarding for persons who fit that description.

If someone becomes ill on board we have worked with the airlines and updated our guidelines so that they are aware of the reporting procedures for persons who will be coming into the United States.

For persons come to the United States all passengers are screened by customers and Board Protection agents at all ports. You know, we routinely work with these agencies and they know how to report CDC. But whenever there's a new outbreak, such as the Ebola outbreak, that can affect travelers we of course enhance our screening.

We have put an additional step into place which we're calling enhanced entrance screening. We are, again, we screen those passengers at - who are coming from the most affected countries. I won't go into the details. If people would like I can answer that in the question and answer section.

We also work with emergency medical services to make sure any ill passenger who is ill on the plane for the - or in the airport can then be safely transferred to a hospital for appropriate care. We work that in conjunction with state and local authorities.

And then state and local authorities are of course CDC's main constituents and we partner with them. And M&M [movement & monitoring] guidance was really written with that audience in mind so that we can have a smooth hand-off of persons who we identify through the screening process and then hand them off to state and local.

So what does the new guidance say? The new guidance first posts - the guidance was first posted in August and was updated on October 27. And there's a long Website for it but if you go our Ebola homepage at www.cdc.gov/Ebola or to www.cdc.gov/travel and look for Ebola and Travelers any of those two websites will carry to the guidance on other documents.

So the guidance updates and helps make sure that people exposed to Ebola are monitored for their symptoms. That people - that systems are in place to quickly recognize the people need to be routed for appropriate care. And when necessary some persons' travel may be limited to help control the spread of Ebola.

The key changes compared to the previous document are that new risk levels for people who may have been exposed to Ebola are now in place and we have actually added a category for persons who do not - are not at risk for Ebola.

There are stricter actions of people who have high, some are low exposure to Ebola. And we have instituted active or direct active monitoring rather than have people only monitor their own symptoms. We have also provided guidance for healthcare workers who have taken care of patients with Ebola.

So what are these exposure levels? To help prevent the spread of Ebola, CDC has provided detailed information about Ebola exposure risk levels. Public health officials are using these risk levels along with assessing symptoms to decide how best to monitor for symptoms and what other restrictions may be needed.

Now it's important to note that just because you are monitoring persons for Ebola that does not mean the individual is sick with Ebola. This is part of the public health strategy to help make sure that if somebody becomes ill over time they can be quickly identified. But the person at times that they are monitored are not ill with Ebola.

Examples of the levels are we are now calling them high, high risk exposure, some risk of exposure, low but not a zero risk of exposure. And we have found it necessary to also now include a no risk of exposure category.

Examples of persons in the high risk of exposure include persons who have direct contact with bodily fluids from a person sick with Ebola who is showing symptoms to, for example, a needle stick, a splash their eye, nose or mouth, getting body fluids directly on their skin, persons who touch a dead body while they're in a country where there's widespread Ebola transmission while they're not wearing appropriate personal protective equipment, or they are not wearing that PPE correctly, or if they live with or and are taking care of a person with Ebola.

Examples of persons in the Some Risk category include close contact, for example, household contacts, persons in healthcare facilities or possibly in the general community that has contact with a person with Ebola while they are not wearing appropriate PPE. Now we're defining close contact as being within 3 feet, that is 1 meter of the person who is sick with Ebola for a prolonged period of time.

Direct contact with a person sick with Ebola in a country with widespread Ebola transmission, even while they're wearing PPE correctly, is also considered some risk.

The Low Risk category includes being in a country with widespread Ebola transmission within the last 21 days even though you may have no known exposure; briefly being in the same room with a person sick with Ebola; brief direct contact, for example shaking hands with someone sick with Ebola; and direct contact with a person sick with Ebola in the United States while

wearing your personal protective equipment correctly. This particularly refers to the healthcare workers.

If you are traveling on an airplane with a person sick with Ebola you are also in the low risk but not zero risk category.

Persons in the No Risk of Exposure category, and this assumes there are no other risk factors, as previously described, are contact with a healthy person who has contact with an Ebola case. That means if I travel abroad and I come back from an Ebola-affected country my family members, who are my contacts, are not considered persons who are at any risk, so they will be in the No Risk category.

If you have contact with a person who has Ebola but that person is not showing symptoms at the time, that is also considered to be no risk. If you left a country - Ebola-affected country - more than 21 days ago, that is beyond incubation period, and you have no contact or you have not become ill since you left that country, you are considered in the no risk exposure category.

And if you have been in a country where there have been Ebola cases but there's no widespread transmission, for example, Spain and United States, you are in the no risk of exposure category.

So let me now go through some of the public health actions that may be taken by state and local public health authorities. Now based on the categories we have just assigned we are recommending that public health actions be taken. These actions could include isolation for persons who are sick or who are confirmed to have a contagious disease.

Active monitoring is - means that public health officials are responsible for checking at least once a day to see if people in these risk levels have a fever or any other symptom of Ebola.

In addition, these persons are asked to take their temperatures at least twice a day and watch themselves for symptoms and to immediately report to public health if they have a fever or any of these symptoms.

Active monitoring must take place for 21 days after the last known exposure and can be on a voluntary basis or be required by public health officials if necessary.

Direct active monitoring means that public health officials make a direct observation at least once a day to see if people have fever or other symptoms. An example of direct observation could be, for example, an in-person visit. A second follow up can then be done by telephone.

Travel restrictions may also be required. This means that people must not travel long distances by airplane, ship, bus or train even if they are not sick. The reason for this is to prevent the possible spread of Ebola if the person becomes sick while traveling.

Some people also - will also not be able to travel on local public transportation including buses and trains or subways as determined by state or local public health officials.

People with travel restrictions must be allowed - might be allowed to travel by private vehicle, such as a private plane or car, as long as they can continue to be monitored during their travel.

There may also be needs for restricted public health activities. This would mean that people must not go to public places where people are in close contact with each other. Close contact means within 3 feet of other persons. This includes places like the movie theaters, shopping centers and activities like jogging in the park may be allowed as long as a 3 feet distance can be maintained.

So what are the recommended public health actions? We have actions for each of the persons in these groups based on the restrictions I've outlined and the exposure levels I've defined.

People with high, some and low risk of exposure who are showing symptoms must have a medical evaluation. They should also remain isolated until doctors and public health officials are certain that they don't have Ebola in order to prevent spreading the disease.

People with high or some risk of exposure should be medically evaluated and isolated if they have a fever, that's a temperature of greater than 100.1 - point 4 degrees Fahrenheit or 38 degree Centigrade or higher; if they feel like they have a fever; if they have severe headache, muscle pain, vomiting, diarrhea, stomach ache or unexplained bleeding or bruising.

People with low but not zero risk of exposure should be medically validated and isolated if they also have a fever as defined or higher or feel like they have a fever, vomiting, diarrhea or unexplained bleeding.

A lower threshold of symptoms is used for people with high or some risk of exposure because they are more likely to have Ebola than those in the low but not zero level. If medical evaluation shows that these people do not have Ebola they will continue to be monitored according to their level of exposure.

People with a high risk of exposure who are not showing symptoms should have direct active monitoring for 21 days after the last potential exposure and extra movement restrictions are needed. These people are required to separate themselves from others and restrict their movement in the community.

The reason for this is to prevent possible spread of Ebola in the person - if the person develops symptoms or fever while they are traveling. People with a high risk are not allowed to travel for long distances on public transportation including airplanes, ships, planes, buses and trains.

People with some risk of exposure who are not showing symptoms should have direct active monitoring for 21 days after the last known exposure. They also need - they need to discuss their travel plans with their local public health department. And the public health department will determine if they will be allowed to travel on public transportation.

People with a low but not zero risk of exposure who are not showing symptoms should be actively monitored for 21 days. People in this category generally will not need to be separated from the community. CDC recommends that they be allowed to travel as long as they do not have Ebola symptoms as they can continue uninterrupted monitoring.

For the group where there's no identifiable risk factor there are no restrictions.

Finally, let me say a word about healthcare workers. Now healthcare workers are of course extremely important. In our travel health notice we have recommended that persons avoid nonessential travel but persons going to provide care in the affected countries have been identified as one of the

essential groups. And these persons of course are putting themselves at some risk to travel to these countries.

So we have taken steps to protect both those persons and also the US population. The guidance for returning healthcare workers from West Africa should be distinguished from healthcare workers providing care for Ebola patients in the United States.

There are important differences in providing care in the two settings. A US hospital provides a more controlled setting than a field hospital in West Africa. For example, a US healthcare worker will be able to anticipate most procedures that would put them at risk of exposure and those where additional personal protective equipment, is recommended.

Therefore healthcare workers who care for Ebola patients in the US who correctly wear their personal protective equipment, are considered to be in the low but not zero risk category. They are not in the no risk category because it is evident that exposures may have occurred that they did not realize.

It is more likely that healthcare workers treating Ebola in the affected countries where there is widespread transmission could be exposed to Ebola and not know that it has occurred.

For example, there could be more possible sources of exposure than in United States. This includes the potential for healthcare workers to be exposed in other areas of the hospital, for example, in triage areas; they could be exposed in the community, they could be exposed while they're doing decontamination procedures if these are not done correctly, or they may not be wearing their personal protective equipment correctly.

Therefore healthcare workers who care for Ebola patients in countries with widespread transmission even while they're correctly wearing their personal protective equipment, are considered to have some risk.

All healthcare workers who care for Ebola patients will be actively monitored by a public health official. This is because they may not realize that they have been exposed.

If a healthcare worker in the US - in a US healthcare facility becomes ill with Ebola and it is not clear how the person became ill, they are going to be considered to be in the some risk category and all other healthcare workers in that facility who cared for the ill patient would also be in the some risk category.

Now if that occurs then public health officials will then review the hospital's infection control practices, fix any problems identified and retrain all of the healthcare workers.

I'll stop there and allow for question later.

Georges Benjamin: Thank you. I think we'll move on to Dr. Perz.

Joe Perz: Yes, thank you very much. So I'm here with one of my colleagues, Abigail Tumpey who can also help elaborate in terms of the preparations and communications to the healthcare community.

So, yes, I'll be speaking about healthcare preparedness. I think this complements very well the material that Clive reviewed because as he was getting into there's importance here in terms of acknowledging and

understanding how, you know, the community and healthcare components interface.

CDC has done a lot of work to provide, you know, not just specific guidance around things like personal protective equipment, or PPE, but to help facilities prepare to safely manage patients with suspected Ebola infection. And so I'd just like to review some what we refer to as, you know, pillars of safety.

So one of our key messages is that facility leadership has a responsibility to provide resources and support for implementing infection prevention precautions. There should be a strong foundation for this, you know, given the baseline of activity around infection prevention and implementation of things like standard precautions.

So this is a very good time for a hospital or health systems management to maintain and promote culture of worker safety in which appropriate PPE is available correctly maintained and which workers are provided robust training on the use of PPE and conducting, for example, exercises, simulations and drills.

There should be, in any healthcare facility, particularly in a hospital setting, somebody designated as the onsite manager in terms of the preparedness for Ebola care.

There should be clear standardized procedures available, and again these need to be practiced and drilled on, particularly in the case of PPE or personal protective equipment.

Oversight is also an important piece. You know, it's not just enough to train an individual but it's important that those individuals receive continual monitoring and feedback.

So I guess again I would, you know, summarize that the main message here is that we're working to ensure that every healthcare worker, regardless of the setting in which they practice, is receiving information about Ebola in a manner that raises their level of awareness.

The idea is to improve the margin of safety of all healthcare workers and patients in hospital and other healthcare settings. Something that we have been striving to do is to continue to tailor guidance for the particular role or setting that a healthcare provider or a healthcare facility is expected to play in terms of Ebola response.

So to that end this week you may have seen guidance specific to emergency department evaluation and management of patients. Similar guidance is near release for more general outpatient facilities. And this supplements and carries on, you know, work that preceded it in terms of preparing those types of sites.

One of the activities that CDC has been very active in over recent weeks is related to deploying what we've called facility assessment and support teams, also known as Rapid Ebola Preparedness Teams.

And in this context we're working as part of state and regional planning efforts. So your state may, and I might say, you know, I expect, has already done planning in terms of how to best array and manage resources within the healthcare system.

You know, everything from preparing sites to do the initial identification, you know, isolation and informing that function that I think Clive, you know, alluded to that facilities need to know and healthcare providers need to know how to - how best to engage the public health system.

So as part of those state and regional planning efforts there's been of course a lot of interest in increasing the capacity of our healthcare system to provide definitive care for a person with confirmed Ebola infection. So we've been working with facilities that have been identified by local and state authorities as candidates to provide that type of care.

Considering, again, that, you know, while for many, you know, Plan A might be, you know, well if we had a patient, you know, we'd like to send them to an Emory, or Nebraska or NIH, you know, that realistically to be well prepared states, regions, particularly those that are receiving a higher volume of return travelers need to have a solution, an option, you know, sort of closer to home.

So what we've been doing is we've been creating teams, typically these would have 6-10 persons on them. There are 3 to 4 CDC and NIOSH staff on each of these teams. The team lead is - has been a CDC employee for all these to date. We have been active in 7 states plus the District of Columbia.

We have on our teams professional partners from groups with expertise in healthcare epidemiology, infection control and infectious diseases, groups like SHEA, APIC and IDSA. We've also been accompanied by additional federal partners at times, having colleagues from Veterans Affairs and increasingly we have had participation from the Assistant Secretary for Preparedness and Response or ASPR.

So the teams are working collaboratively with these hospitals to help them assess and support their mechanisms, their infection control readiness, if you will, walking through, you know, various domains where preparedness is required, everything from, you know, design of the facilities that would be intended to provide such care, staffing issues, infection control aspects, waste management, environmental health, communications, many dimensions of preparedness are considered.

The teams offer assistance and guidance including recommendations for follow up training. They're not there to certify a facility, as a so-called Ebola ready. And ultimately that is, you know, a function of the state licensing authorities, accreditors and so on.

But again, I think the key here is that the teams are helping government officials and health systems, you know, identify facilities that are most well suited to safely care for patients with suspected or confirmed Ebola virus disease.

This type of activity has certainly been ramping up in the wake of the enhanced entry screening. And I see that work continuing as we are instituting the active monitoring of the return travelers.

So again we're working in different facets of preparedness, looking at different dimensions, everything from, you know, materials that a healthcare worker could access as an individual, materials that could be used for training on site including videos that are being developed, you know, with detailed guidance in terms of PPE and how you put that on and how you take it off safely. And then for facilities that have, you know, more clearly defined specific roles there's even this, you know, onsite support that I just described.

So I think I might pause there and turn it back to the moderator and want to leave plenty of time for questions of course.

Georges Benjamin: Thank you very much, Dr. Perz. Leeanna.

Leeanna Allen: Thank you, Dr. Benjamin. And good afternoon from Atlanta and thank you to everyone on the call for participating. I'm part of CDC's Joint Information Center, sometimes you may hear it referred to as the JIC. And our role is to coordinate communications across CDC and across all of our partner agencies to ensure accurate, consistent and reliable messages to a variety of audiences. And as you can imagine this is quite a job in the current Ebola response.

CDC is using many different communication tools in our response. We are constantly updating our communication products and webpages with new information on the outbreak both for the general public as well as for specific audiences.

We have information for travelers, for humanitarian aid organizations, for public health departments, for healthcare workers in a variety of settings, both in the United States as well as West Africa.

Our Ebola materials come in many different formats. We have videos, infographics, fact sheets, audio PSAs, checklists, posters, guidance documents just to name a few.

We're also using social media as a way to share credible factual information and to dispel misconceptions about Ebola. In fact, a CDC-hosted Ebola Twitter chat on October the 2nd, had the largest reach of any CDC chat we've had. And we've been breaking all of our records in terms of calls to our 1-800-CDC-INFO number, emails and website visits.

Another communication tool we're using is exactly what we're doing today; we've been conducting, organizing and participating on conference calls, webinars and trainings for healthcare workers, state and local health departments, faith-based organizations, community organizations, private sector partners, humanitarian aid organizations both here and abroad and many others.

And often on these calls we get the question from people on the call asking, so what should I be doing now? So I wanted to take a few minutes to give you some ideas from the communications perspective.

First of all, we know that people have a lot of questions about Ebola and there's a lot of information out there. Unfortunately not all that information is accurate. We want to encourage all of our emergency response partners to help us provide education and community outreach. This is also critical - there's also a critical need for our public health communities to help us in the fight against stigma.

We have many resources available on www.cdc.gov/Ebola that you can use for community outreach handouts or post to your own Website or social medial channels. And speaking of social media, be sure to follow, re-tweet and share CDC Twitter and Facebook updates with your networks.

Secondly, and with flu season fast approaching, this is an opportunity for public health to promote healthy hygiene habits like hand washing. We want to take this opportunity to encourage community partners to connect with public health initiatives through volunteer coalitions, business preparedness groups or local emergency planning committees.

We have been doing some outreach calls with charitable organizations in the private sector who may not have that connection with their public health departments. And this is a chance for that connection to be made not just for this outbreak but for future outbreaks.

I would also like to put in a plug to - for everyone to subscribe to our online emergency partners news bulletin. This bulletin is sent out weekly but sometimes more depending on the response activities. And the bulletin contains announcements, links to guidance documents and key messages about all aspects of the CDC Ebola response.

To subscribe visit www.cdc.gov/other/emailupdate - that's all one word - and click Subscribe. You'll enter in your email address and then have the opportunity to select subscription topics. Under Office of Public Health Preparedness and Response, select CDC Emergency Partners. You'll also find many other help topics you can subscribe to for future reference.

We know that in risk communications our goal is to be first, be right and be credible. So thank you all very much for everything that you do to support public health everyday.

And at this time I'll turn it back over to Dr. Benjamin.

Georges Benjamin: Well thank you very much, Leeanna. Operator, we're prepared to take some questions.

Coordinator: All right, thank you so much. If you'd like to ask a question please press star 1 on your phone at this time. Again, that's star 1 on your touchtone phone if you'd like to ask a question. One moment please.

All right, it looks like our first question is from (Shawn Faye), your line is open.

(Shawn Faye): Thank you, everybody. Greatly appreciate the information that was put out this morning, or this afternoon. I have a statement and a question. The statement is, bluntly, the emperor has no clothes. I have been working - I'm an emergency manager and I work with local emergency response organizations, shelters and emergency groups.

And they are looking for this information from our state and local health organizations - public health organizations and it's not being put out. We held a briefing a week or so ago and invited people from public health to come and they said, well, we're waiting until we get a - we don't want individual groups putting on their own presentations; we're going to do it all together.

Well, we're still waiting for them and we've already done our presentation. So people are still getting information, and we're getting it from the CDC Website but there needs to be a push to get it out there faster to the responders that matter.

Thank you.

Georges Benjamin: (Shawn), Georges. What state are you at?

(Shawn Faye): I just left Massachusetts. I'm in North Carolina right now.

Georges Benjamin: Okay.

(Shawn Faye): But I did that - I did that briefing in Massachusetts. And I called up and I asked for some assistance and I called Boston EMS for some help. I have

some friends there and they said, well let me check with my boss and see if it's okay. And a week after I did the presentation I got a call back that said, yeah, they said no.

Georges Benjamin: Got you. Well we'll...

(Shawn Faye): Not to pick on them and everybody is trying to get it right. But you got to be first and you got to be right. If you wait too long we're, you know, the public is looking for information faster than we're giving it to them and they need it. And it's the firefighters, the EMTs, the emergency managers at the local level are looking for this information.

Abbigail Tumpey: This is Abbigail Tumpey from CDC. And this is - the sentiment that you're conveying is what we're hearing from many different directions as well. I've been tapped to help the agency coordinate healthcare worker outreach broadly which includes, you know, a variety of frontline healthcare workers.

And we've done a fair amount but we're still hearing stories of gaps. We're also, you know, we know we can continue to do webinars but that's not - that doesn't take the place of, you know, the hands on training that really needs to happen at a local level.

So one of the things that we're doing at a federal level is having discussions to see how we can leverage the various federal resources of entities who do regular on site hands on training to ensure that particularly in the localities where, you know, we would expect them to have a higher percentage of return travelers that those individuals are targeted and trained appropriately.

So we're working with a variety of EMS organizations, frontline healthcare workers, healthcare unions, hospital associations, different professional organizations, etcetera.

We have a slew of additional materials that are going to be forthcoming that are all going to be kind of web-based curriculums. But one of the things that we're also looking to do is to identify organizations that can help us with a train-the-trainer type model so that we can...

(Shawn Faye): Ma'am, I can help you with that one right now. The National Fire Protection Association and the National Fire Academy. I'm getting these questions from the fire service and all though CDC did - is talking to APHA and the public health everywhere, to be honest, what we do in public health is critical but most people do not know where their local public health office is.

Abbigail Tumpey: Yeah.

(Shawn Faye): And it's just - it's just that. We can talk to one another and it's like being in academia. Yeah, we all know it but the rest of the world who's doing the response, they need to know it. And they need to be confident that they know it.

Abbigail Tumpey: Exactly. Exactly.

(Shawn Faye): So if it can get pushed out to major things like...

((Crosstalk))

(Shawn Faye): ...firefighter organization or police organization or EMS organization you can touch, ask them to send it because those are the people who are asking for it.

Abbigail Tumpey: Yeah, we totally agree with you. So thank you for that information and kind of feedback. And, you know, we will look how we can kind of redouble our efforts towards those groups.

Georges Benjamin: Thank you, (Shawn). Next question, Operator.

Coordinator: Thank you, our next question is from (Leslie Cooper). Your line is open. Miss (Cooper), you may have your line on mute.

(Leslie Cooper): Okay, I did just unmute it. Thank you very much. Foremost I want to say thank you so much to Dr. Benjamin for helping to set this up. I bugged him via email and I'm so sorry but I really, really appreciate it. I'd like to know when this information will be available on the archive piece so that we can get it out to others. That's one question. The call is being recorded, right? So it's going to be available.

Georges Benjamin: It is going to be recorded. And, Leeanna, do you know how soon that would be available from your end?

Leeanna Allen: Yes, we will work to get it up on the CDC website as soon as we can, hopefully next week. And that address is www.cdc.gov/PHPR/partnerships/Ebola.

(Leslie Cooper): Well thank you. And I'd like to echo the comment that the person made before me because there's a lot of information and people are really panicking. And so we've got to do a better job. I heard you say there are a number of things CDC is doing with social media and etcetera getting the information out. It's really not getting out to a lot of the grass roots people that are out there - I'm

retired military but I do a lot with faith-based organizations and the community and they need the information.

So anything we can get out in terms of PSAs, we've got to get more information out to the public as soon as possible.

Georges Benjamin: (Leslie), this is Georges. If I could also refer you to the Get Ready fact sheet that we put out which I think is perfect for community organizations, faith based groups. If you go to APHAgetready.org...

((Crosstalk))

(Leslie Cooper): ...it out already. As soon as you sent it...

Georges Benjamin: Got it, okay.

(Leslie Cooper): As soon as you sent it I sent it out.

Georges Benjamin: All right.

(Leslie Cooper): So that kind of information, anything that we can get out, I mean, we need to have that because people are hungry, people are panicking. And we definitely do not want to stigmatize people because of this issue. And when the public health representatives and commission officers and etcetera come back from serving, we don't want to stigmatize them.

There's been some question about when they come back to their offices where are they going to work. And so we've got to address this issue early on.

Georges Benjamin: Thank you, (Leslie).

(Leslie Cooper): Thank you.

Georges Benjamin: Operator, next question.

Coordinator: Our next question is from (Angela Laramie), your line is open.

(Angela Laramie): I'm actually going to pass, thank you.

Coordinator: Thank you. Our next question is from (Helene Bednarsh), your line is open.

(Helene Bednarsh): Hi, this is (Helene Bednarsh). I'm with the Oral Health Section just so that you'll know some of these questions are dental-related. I just would like to mention in terms of partners, Leeanna, you should consider the National AIDS Education and Training Centers. You can find them at HRSA.gov. And they're a good resource to partner with.

Another one is OSAP and it is the only dental infection control organization globally. We just held a conference call with the American Dental Association two days ago and we've developed a toolkit and other information for dental healthcare providers at OSAP.org and we're making it public, not member-only information.

And we're trying to look at the CDC Do You Have Ebola fact sheet. We'd like to see that modified for ambulatory care settings at OSAP. We had developed a checklist during H1N1 that has been used throughout for the front desk to begin screening and to have receptacles, tissue, hand wash, masks available so we'd like to see something.

Not that we're expecting somebody infected with Ebola to necessarily show up in the dental clinic but we feel that we need to be prepared for that as well.

Georges Benjamin: Thank you, very very much. And I know CDC got that message. Next caller.

Coordinator: Our next question is from (Carlisia Hussein). Your line is open.

(Carlisia Hussein): Thank you. And congratulations, Dr. Benjamin and all the team for making the presentation today. Of course I've been a member for years of APHA.

Actually I'm reiterating the comments made previously but I thought it was worthwhile to be a little bit repetitive. And my concern is that a lot of good information is going to providers and persons in the frontline. But the general public really really needs information as others have said.

And I think I've been looking over the various Websites while we were talking and it's quite good. And I would like to know where one or two email links is where I can get the information that is printable because some of this, when you try to print it, we're dealing with organizations that are still doing face to face work it doesn't convey that well. I may just have missed it.

The other thing is there are a number of organizations that are grass roots that could help spread this word because we really need an army working with us. Examples are health centers, community-based organizations, of which there are many, the offices of minority health around the country, the Centers on Aging. Well, you know, we could go on and on.

But information that's readily available and I'm always interested in the low tech approach because everybody is not proficient with websites and portals and all of that so if we don't have a balance in the methodology of transmitting information there's a whole segment of the population that will not get it.

So my question was if someone could kind of point out a link or I'll just keep searching until I can find some of the best information that I can forward to my contacts certainly in Maryland where I work and around the country.

Georges Benjamin: Leeanna, I know you folks at CDC have that on your webpage. Can you direct her to your webpage?

Leeanna Allen: Yes, Dr. Benjamin. Our webpage, www.cdc.gov/Ebola, on that homepage on the right hand sides there's a bar that will provide a link to all of the communication products that we have. We do have some that are - would be great printed out, infographics, posters, things like that. And you can find previews for those on the communications website and we'll continue to update that as we have more information.

But we do know that we have a lot of people who like that visual, who like the printed out handheld thing so we have that available for local organizations who are interested in having that resource available.

Georges Benjamin: Thank you.

(Carlisia Hussein): Thank you, I'll keep searching.

Georges Benjamin: Thank, Dr. (Hussein). And call me if we need to talk about that offline as well.

Coordinator: All right, our next question is from (Robert Bernstein). Your line is open.

(Robert Bernstein): Hi, it's Dr. (Bob Bernstein), can you hear me?

Georges Benjamin: We can, (Bob).

(Robert Bernstein): So I have two comments. One is although it's buried in one or several of the webpages that CDC gave Ebola, I don't think there's been enough emphasis of the importance of advocating for influenza seasonal vaccines among travelers and it's an issue that I do think that needs to be raised in connection with the concern over returning travelers and they have symptoms similar to flu that might initially be thought of as Ebola.

The second comment is that I think there's not enough clarification on the meaning - the definition and the purpose of isolation as contrasted with quarantine. The media often confuse this and so I think it's worth somehow highlighting a set of definitions on the Ebola site.

I do want to thank CDC and APHA for the quality of the information that is available and I'm - and I much appreciate the accessibility of that. Georges, is the -I think I heard that this webinar - this particular one is going to be archived and available, is that correct?

Georges Benjamin: It will be recorded. It'll be probably next week before it's on the CDC Website. And we will certainly link to it from our Website but I'll be next week.

(Robert Bernstein): Okay thanks.

Georges Benjamin: And we'll send an email out to all members to let you know it's available.

(Robert Bernstein): Thanks.

Coordinator: Thank you. Our next question is from Dr. (Anthony Robbins). Your line is open.

(Anthony Robbins): Hello, Georges and colleagues. I have a question because as I have been reading the guidance out of CDC and what has been available through APHA, it doesn't offer a link to the data from which these recommendations derive. And it would be very useful to understand where the information comes from.

Let me site only one example. CDC seems to draw a very bright line between airborne and droplet-borne problems. And as a former director of NIOSH, having dealt with airborne and droplet-borne problems, I think that bright line may be there but it certainly isn't bright.

And so it would be very useful for all of the CDC recommendations to know what are the sources of data that led to the recommendations.

Georges Benjamin: Okay, I'm going to pass that on to CDC to let you - to answer that one. But just - I know that this is a big issue. I know that CDC is in the process of updating their Website in this area of droplet protections, etcetera and I think trying to get some clarification. But maybe, Leeanna, you know the answer to that.

(Anthony Robbins): Well let me just - one stop farther because I'm pleased that the CDC is doing that. One of the things one learns, I think, I did as a state health officer, is that when you change your position it is very important to be open about the fact that the early position wasn't quite right. Otherwise, there's a tendency for

the public not to trust the recommendations that come out of public health agencies.

Man: Got it.

Abbigail Tumpey: Yeah, so this is Abbigail Tumpey. So just with regards to the airborne droplet materials, those - we do know that that had been confusing and we updated those and those are live on the Website now.

We do take your point with regards to making sure that we're referencing kind of the scientific base and we attempt to do that in the various guidance documents but we'll look to make sure we do a better job of that.

With regards to...

((Crosstalk))

(Anthony Robbins): ...hard to find what the data are and where they came from.

Abbigail Tumpey: And then with regard to the guideline issues, you know, I think one of the things that we found is that our previous guidelines allowed for kind of wiggle room and kind of a ramp-up of what individuals should do in a healthcare facility that as the patient got sicker they should have additional PPE.

I think what we realized is that that, you know, one could potentially be confusing but, two, as we've seen with, you know, care versus - African care settings versus US care settings where we are doing much more, you know, invasive procedures that may expose healthcare workers, that was really the - hence the reason, you know, we looked at doing a higher level PPE in which there was no skin exposed.

And so all of that information has been updated across our Website as Dr. Perz detailed. Thanks.

(Anthony Robbins): I think you're doing very well. It would be - it would be very useful when I see that you're getting help from NIOSH to remember that there is the Occupational Safety and Health Act which makes the employer responsible for providing a safe and healthy workplace.

And I don't think there has been sufficient emphasis on what the management of hospitals and other health facilities, not only can do, but must do under the law.

Abbigail Tumpey: Yeah, and so the guidance that has been released is, you know, co-written by our infection control division, Division of Healthcare Quality Promotion and NIOSH. It was also reviewed by OSHA...

(Anthony Robbins): Good.

Abbigail Tumpey: Doctors Without Borders, Emory, NIH, Nebraska, numerous external experts in both occupational health and infection control to ensure that we were making sure we were covering all the bases.

(Anthony Robbins): No you're absolutely - the guidance is good on what people ought to be doing. It is not been good on who is responsible for doing it. And it tends to have a tone - and I don't want to overstate this - that the workers are responsible for protecting themselves when in fact the employer is responsible for protecting workers in this country.

Abbigail Tumpey: That's exactly right. And we really tried to emphasize that with the release of the updated PPE guidance. And we're trying to make sure that employers do know that they have a responsibility for ensuring that all of their staff are trained, they have practiced, that they have demonstrated competence and that there's a trained observer to ensure that all areas of infection control are appropriately managed.

(Anthony Robbins): Many thank you.

Georges Benjamin: We're only going to have an opportunity for a question or two, so thank you, (Tony). Next question.

Coordinator: Next question is from (Walter Saranicky), your line is open.

(Walter Saranicky): (Walter Saranicky). I'm an environmental health practitioner in private practice in Illinois. I would like to go back to under the topic of travel restrictions on public transport. Can you tell me where do taxis and uber-type travels stand?

Clive Brown: Sorry, taxis and?

(Walter Saranicky): Uber like travel.

Clive Brown: Right, so in general, persons in the high and some risk category aren't allowed to take public transport. Taxis, local transport, may be taken by those in the some risk category if it is discussed with the local health department.

So each health department may have specific restrictions so it's hard for me to say specifically where taxis would fall. But, you know, many taxis for example, have a barrier between the driver and the passenger behind so the

health department may determine that to go from point A to B we're - and the person is not in a crowded environment that a taxi would be suitable.

I'm not entirely sure how the uber cabs or whatever they call them are configured. I don't know if they have the same barrier mechanism. So they probably do not so a public health department may decide that uber transportation is not appropriate for persons in the some risk category. But it will depend on the health department and what they know of the transportation for taxis in their area.

Georges Benjamin: Thank you, Doctor. One final question.

Coordinator: Our next question comes from (Lynn Davis).

(Lynn Davis): Hi, everybody. Can you hear me?

Georges Benjamin: Yes we can.

(Lynn Davis): Yes, I am a public health professional who works for a private company. We develop online interactive training that features conversations. My question is, how can we work with both federal and local health departments and organizations in order to develop training that helps the public?

Abbigail Tumpey: So this is Abbigail Tumpey at CDC. I think one of the things that we're doing is working with OSHA and HHS and a group at NIH to develop some training materials that could be utilized by a variety of partners including state and local public health.

But there are - there's a fair amount of resources out there already and there's several states who actually have created their own resources, for example,

Tennessee, you know, created some materials specifically on how to do a drill in hospitals.

So there's a fair amount of resources out there but if folks have specific training needs we actually have set up a box at CDC and that is eocevent100@cdc.gov. That's eocevent100@cdc.gov if there's specific questions or needs and you can funnel those to those boxes and we will - we'll work to see how we at CDC can try to meet that.

Clive Brown: And add to that if you're in a specific state you should contact your state local public health authorities they may have a similar mechanism as was just described.

(Lynn Davis): Thank you.

Georges Benjamin: With that I want to - we've got to bring the call to a close but I want to thank all of you - I know there are many, many people out there who have questions. Want to obviously direct you to your state and local health departments for some of those questions. Please go to the - both the CDC.gov Website and the APHA.org Website and hopefully there's information there that would aid you in this process.

For many of you we will see you in about two weeks at our annual meeting where we will have an Ebola session but hopefully the dialogue will continue in the halls as we go forward. And I want to just personally thank our colleagues, Dr. Brown, Dr. Perz and Miss Allen for their - being on the call today and beginning the conversation that I think we need to have in this country. And my staff and I have heard you and we will continue to try to get information as quickly as we possibly can through APHA.

So thank you very much and I need to, unfortunately, bring the call to an end.

Coordinator: This concludes today's conference. Thank you for joining us. You may now disconnect. Speakers, please stand by.

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