CDC Press Releases

Update: CDC Ebola Response and Interim Guidance

This website is archived for historical purposes and is no longer being maintained or updated.

Press Briefing Transcript

Monday, October 27, 2014 at 3:30 E.T.

- Audio recording[MP3,10 MB] (https://www.cdc.gov/media/modules/releases/2014/AUDIO-EbolaUpdate102714.mp3)

OPERATOR: Welcome and thank you for standing by. All lines will be on listen only until the question and answer session of today's conference. At that time, to ask a question, please press star 1 on your touchtone phone. Again that's star 1 to ask a question. This call is being recorded, if you have objections, you may disconnect at this the time. I would now like to introduce Mr. Tom Skinner. Sir, you may begin.

TOM SKINNER: Thank you Jennifer, and thank you for joining us today for this update on the U.S. response to Ebola. We'll be going over some interim guidance that the CDC is releasing today for the monitoring and movement of persons with potential Ebola virus exposure. With us today is the director of CDC Dr. Tom Frieden who will provide opening remarks and we'll get to your questions, Dr. Frieden.

TOM FRIEDEN: Good afternoon everyone and thanks for joining us. Today CDC is releasing new guidelines that use our experience to increase the protection of the health and safety of Americans which is our first priority. Health care workers doing heroic work protecting the U.S. in West African countries, which are heavily affected may return to this country and these guidelines outline what can be done to protect them and to protect our communities. They rely on individualized assessment. They rely on the experience that we've had over the past month. Today marks exactly one month since the first case of Ebola diagnosed in the U.S. or anywhere in this hemisphere. Mr. Duncan was diagnosed on September 28th. Since his diagnosis, three more individuals have been diagnosed with Ebola in the United States. This is unprecedented, managing Ebola is not easy. And what we're doing with these new guidelines is using experience and data to refine the policies and programs that we recommend. At CDC, we base our decisions on science and experience. We base our decisions on what we know and what we learn. And as the science and experience changes, we adopt and adapt our guidelines and recommendations. I'd like to recap a couple of things, first about the disease, and second about what we're doing to stop it. Ebola only

spreads from people who have symptoms of the disease. And it only spreads through direct contact with someone who's sick or their body fluids. The highest risks are in people who are providing care giving, especially as patients become increasingly sick. And in West African where burial practices are different, burial can also be a source of transmission. It's worth remembering some of the classic studies done of Ebola over past years, including a study by CDC authors that systematically monitored all 173 household members of 27 patients with Ebola. Of the household members, over all, 16 percent developed Ebola. But, of the 78 household members who had no direct contact with patients with Ebola, despite living in the same house or hut in Africa, despite sharing meals and being in the same household, zero became ill with Ebola. That doesn't mean there's zero risk to contacts, but it does mean that Ebola spreads primarily by contact with body fluids or body of someone who is sick with Ebola. I'd also like to recap the different levels of protection that CDC and our partners throughout the U.S. government and globally are implementing. First and foremost is working to stop Ebola at the source in Africa. CDC today has more than 160 staff in the field helping to lead, guide, and support all aspects of the response. We work very closely with our partners throughout the U.S. government, US-AID, the Department of Defense, the State department, as well as our global partners. In addition, since summer, we've been doing exit screening on all people leaving West Africa, identifying those with fever and removing them before they board the aircraft. Beginning on October 11th at JFK and October 16th at the other four airports we've been screening all entrants for fever and exposure to Ebola. Starting a week ago Saturday, we began providing to all entrants care kits, check and report Ebola. These kits consist of a thermometer, health education materials, information about how to contact the local health department or health care providers, a card to show if they become ill, and seek care. And since beginning the entry screening to the U.S., we've also been providing information on the names, addresses, and other contact information of all travelers returning to state health departments, so that they can monitor the care and the progress of people who are going through their 21 day incubation period. CDC has also worked with health departments throughout the country to expand a laboratory response network, so individuals who are suspected can be rapidly tested and that can be assessed. We sent rapid Ebola preparedness teams to hospitals around the country so they can be better prepared in the event of someone with suspected Ebola. We've established an Ebola response team, any time there's a highly suspected or confirmed Ebola case, that team is at Bellevue today working side by side with the excellent clinicians of that hospital to improve the safety and improve the care of that individual. And we've established protocols for management of individuals in emergency departments who might have Ebola. Through all of this, we expect there to be an increasing number of individuals for whom there is a concern that they might have Ebola. That doesn't mean there are more cases until a laboratory test confirms case, it's not confirmed. But the series of steps add levels of protection to the U.S. Also, starting today, the six states through which 70 percent of all of the returning travelers return will be doing an active monitoring program to monitor their health on a daily basis so that if they develop symptoms, they can rapidly be assessed and if they're found have Ebola, effectively isolated and treated. The new guidelines increase the level of protection by outlining different levels of exposure and outlining different public health actions that can with taken for each levels of exposure. We identify four different levels. The first are high risk exposures. Things like a needle stick from someone whose been caring for Ebola patients. Or someone who had a known exposure to a patient with Ebola, for example, a family member who cared for someone when they were sick without using protective equipment. The next level is the

some-risk category. In that category, we include someone in the household of a patient with Ebola but didn't provide any direct care or direct contact, or a health care worker returning from Africa where they've been caring for patients with Ebola. We've had about 100 or a little under 100 individuals per day on average, returning from the three affected countries in West Africa. Of those, about five or 6 percent have been found to have a background of working in health care. Specifically, it's been 46 out of the 807 people who we have evaluated. There's also a low, but non-zero risk, such as someone whose been traveling within the affected countries, but has had no known exposure. And we would put into that category also a health care personnel, doctor, nurse, or other health care staff. We've been working at the United States facility caring for an individual with Ebola. Bellevue, Emory, NIH, and Nebraska, are the facilities currently doing that. For those individuals, they have important decisions from providing care in Africa versus in the U.S. hospitals have a more controlled setting than a field hospital in Africa. And the staff, ratio is very different. So in that category, we consider them to be of low but non-zero risk. And the fourth category is those who have no identified risk, for example, individuals who did not travel to one of the affected countries or traveled more than 21 days ago. We've received over 500 inquiries about concerns that patients might be at risk for Ebola. In 90 percent of those inquiries, there's not a symptom pattern or a travel history that's consistent with Ebola and for the remainder, we've been able to facilitate rapid testing. In terms of the public health actions that can be taken. The first and most important is active monitoring. And that means that the health department, the local public health authority takes the responsible for a daily monitoring of the individual symptoms and of their temperature. And if people have symptoms or elevated temperature, they're rapidly assessed, evaluated, and if appropriate, isolated, cared for, treated. This type of active monitoring is so important because it can identify people early in the course of illness. And with know with Ebola, as people get sicker, they get much more infectious. The first few hours or days of the beginning of symptoms are far less likely to result in any infections than are the later courses of disease when people have much, much larger numbers of virus that they are excreting. In cases that there is a high risk of an individual potentially becoming ill or based on an individualized assessment of the exposure, of the activity, of the individual, of the circumstance, additional restrictions may be placed. Those may include on an individualized basis, what's called a do not board order, which would prevent the individual from getting on a flight. At the local level, restrictions on use of public transport, work, or attendance at congress activities. But fundamentally, people want to do the right thing. And what I'm hearing from returning health care workers and others is an interest in making sure that they are cared for effectively and they are responsible, so that if they do develop any symptoms, they're rapidly isolated and treated. In fact, doctors without borders, MSF, has had very clear guidance for their staff for their own protections. They should stay within close radius to a facility that can care for them and this is the kind of approach that we think will be affected, in addition, while i understand there are concerns, that individuals may not fully disclose information about their history, I think concerns about illness are of a very different order. Health care workers of all people understand that if they develop Ebola, sooner, the sooner they get care, the more likely they are to survive and the sooner they get isolated, the less likely they are to infect their family members. Overall, there's real progress in different ways in the Ebola response, but we're still far from out of the woods. In Texas we have seen the health care workers complete their 21 day observation period, two nurses became infected in all likelihood in the initial days of Mr. Duncan's illness. In New York City, we continue to monitor closely, the illness of dr. Spencer, and monitoring of his contact. In Africa

we have served along with the world it's going to be a long hard fight and the assistance of health care workers from around the world will be we will only get there by stopping it at the source. While we're trying to do that, we are also implementing a series of measures to reduce the risk in the U.S. bottom line is, we're today, releasing new guidelines on the monitoring and movement of people who may have been exposed to the Ebola virus. These guidelines increase the level of protection of the health and safety of Americans, which is our first and foremost concern. While at the same time, recognizing the heroic work that going on in West Africa by the individual or some of the individuals that's protecting us from the disease. Thank you.

TOM SKINNER: Jennifer, I believe we're ready for questions, please.

OPERATOR: The first question comes from Miriam at the CNN Medical News. Your line is open.

MIRIAM FALCO: Hi Dr. Frieden, so you're saying individual live basis some states are saying people coming back who may have been exposed who we know were exposed, like health care workers, need to be quarantined immediately. What are your specifics statements on that and how does that fit into the new guidelines? And then do you know anything about the five-year-old in New York that may have or may not have Ebola. And is there a faster way to test for Ebola instead of the PCR testing that takes six to 12 hours?

TOM FRIEDEN: All right. Well first, the level of monitoring and restriction placed on individuals in our new guidelines depends very much on their particular risk. For someone with high risk, someone who for example had a needle stick while caring for a patient with Ebola, that individual we would certainly want to have on controlled movement, not on any public conveyances, not out in public places, excluded from workplaces except teleworking or approved by the local health department. That has a disk than someone whose been providing care in West Africa. That we consider to be a some-risk experience. And for that experience, the single most important thing is to rapidly identify, if they develop symptoms. And we are recommending that that be done by what we're calling direct active monitoring. Than means that someone who is accountable to the local health department or state health department observing z as their temperature is taken. That person also has a conversation with the individual, both of these things on a daily basis about how they're feeling, and goes through a detailed list of symptoms to see if they have anything even as vague as fatigue that might be of concern. And reviews with them what their plans are for their activities. So that if they're planning to stay at home, that's one thing. They're planning to take other activities; there would be an individualized assessment of what makes sense for that individual at that time. Some of the things considered in that assessment are what was the nature of exposure, what kind of work was being done? Is the person completely symptom-free? Are they able to rapidly seek isolation and care if they were to develop symptoms, and at what point they are in their incubation period? We know that from the data in Africa, it appears that more than 90 percent maybe even more than 95 percent of the cases that will occur in the first two weeks or roughly 14 day period. So that's the nature of the individualized assessment. And that we think is good, sound, public health policy. In terms of testing, the PCR test takes only about three hours. It takes shorter period of time if it's strongly positive. It has to be repeated because it's borderline. The challenge is too often get the specimen to the testing laboratory. That's often a longer delay than the actual testing itself. In terms of the young child at

Bellevue, we would refer your questions to the hospital there from the information we've seen, the illness would be quite unusual as a presentation of Ebola.

TOM SKINNER: Next question, Jennifer.

OPERATOR: Okay. To ask a question, you may press star one on your touch tone phone, unmute your phone and record your name. To withdraw, press star two. The next is from Richard Besser with ABC News, your line is open.

RICHARD BESSER: Thanks very much, Dr. Frieden. The guidance that you're announcing, it sounds like snot require that– not require that returning health care workers come to home quarantine. Less stringent than many states. I know CDC doesn't have enforcement authority. If a patient, or if a returning health care workers flies into one state, they may be held there, if they fly into another, they may be able to get home and not be under home quarantine. It sounds like we're dealing with a patch work. How do you get away from so many different things in different parts of the country?

TOM FRIEDEN: With these guidelines we're engaging in discussions with state and local governments. We find that state health departments generally do follow CDC guidelines. If they wish to be more stringent than what CDC recommends, that's within their authority and the system of government that we have. We believe these are based on science. And these add a strong level of protection and a strong level of reassurance that someone who is in the some-risk category such as a returning health care worker is going to be intensively monitored with their temperature, actually measured, each day, and a careful review of their symptoms. That, plus the information that we're providing to each returning traveler is we think what most protective of both the health care workers, families, and communities. We do have to recognize that if we do things that make it very difficult for people to come back, if we turn them into pariahs instead of recognizing the heroic work, a couple things may happen that none may. They may be less likely to disclose their health care worker status and we lose the opportunity to directly monitor them. They may be less likely to go help stop it at the source in Africa, and with that, if it spreads further or longer in the three countries or we can't control it there, the risk to us would increase.

TOM SKINNER: Next question, Jennifer.

OPERATOR: Yes, the next question is from Shelby of Bloomberg TV. Your line is open.

SHELBY HOLLIDAY: Hi Dr. Frieden. I'm curious how many people you are actively monitoring right now or actively being monitored and also if you have updates on the five-year-old boy.

TOM FRIEDEN: As I said earlier, you'd have to refer to Bellevue for the status of the five-year-old child, but the pattern of illness as we've understood it is not the pattern of illness that we would expect to see in an individual with Ebola. I think the testing will be back in the near future though, at least a preliminary testing from the CDC laboratory response network at the New York City department of health. In terms of the number of people to be tracked, there are so far, a little less than 100 people per day entering the U.S. there have been 807 so far. Of whom 46 have been identified as health care workers or otherwise would be in the

some-risk category. And that is for, from the beginning of the program that started at JFK on the 11th of October through the 25th of October.

TOM SKINNER: Next question please.

OPERATOR: The next question comes from Mike of the Associated Press, your line is open.

MIKE STOBBE: Hi, thank you for taking my question, doctor, I think you might have just clarified one thing, you talked about 100 per day, and i wasn't clear, that was a mix of what visitors from West Africa, people who lived there and were visiting and also health care workers, and also, sir, if you could just go over, I'm sorry, but I found it confusing, you outlined four categories, high risk, some risk, low risk, and no risk. I wasn't clear which new recommendation went with which. Are you recommending at home voluntary quarantine and then for some risk health departments, active monitor– could you go over that again?

TOM FRIEDEN: Sure, first the numbers. When we began discussing some of the entry screening we were using the number of approximately 130 to 150 travelers coming to the u.s. per day. Actual experience has been averaging less than 100 per day since the program started. Most of those individuals are U.S. citizens, or legal permanent residents. Of those let's say less than 100 per day have been returning health care workers. Of the four categories of risk the guidelines that should be posted on the CDC site outline both management of people who are symptomatic or evaluating them for Ebola and asymptomatic. As you stated for the high-risk individuals, we are recommending voluntary at-home isolation, including not going on public conveyances, not flying, and doing what's called direct active monitoring or making sure that someone is observing and discussing with the person each day in terms of their health status and monitoring their temperature. The– for the some-risk individuals and we consider the health care workers returning from West Africa to be in the some-risk category, they would also undergo direct active monitoring, and then the public health authority based on a specific assessment of that individual situation would determine whether additional restrictions are appropriate. Those might include not going on planes and buses and trains, being excluded from public places and gatherings and being excluded from workplaces. Other activities would be assessed as needs and circumstances change, but any travel would need to be coordinated and preapproved by the public health authorities at both the origin and the destination with the goal of ensuring that there is uninterrupted directive active monitoring.

TOM SKINNER: Next question, please.

OPERATOR: The next is from Dennis Thompson with HealthDay , your line is open.

DENNIS THOMPSON: Thanks for taking our questions. Just to consider that going down to low shall have risk, would the low-risk folks be the people under active monitoring, but by phone, kind of as many of these people are who have been under observation in Texas?

TOM FRIEDEN: So let me– first off for the low, but non-zero risk, yes, the active monitoring could be by phone. You refer to the Texas outbreak investigation in control activities, this is guidance that refers to both travelers returning to the U.S. and anyone potentially exposed in the U.S. so in the Texas investigation, the health care workers who might have been exposed

the infection control procedures which were in place did not prevent two nurses from becoming infected. Those individuals would be considered high-risk of infection in contrast, health care workers working for example at NIH or Emory caring for Ebola patients are considered at low, but non-zero risk. And then contacts of individuals with Ebola are assessed based on their specific level of risk.

DENNIS THOMPSON: Were people held in Dallas, the high-risk folks? Were they held in at-home isolation or is this something new?

TOM FRIEDEN: This tells what the experience was in Dallas that individuals at the highest risk first were asked to ensure that they were actively monitored, and if there was any doubt that they could be actively monitored they were asked to stay at home. They were very small number of people in that category in new york city, there are three contacts who were in the potentially close contact or high-risk, all three of them are being asked to stay at home.

TOM SKINNER: Next question, Jennifer.

OPERATOR: The next question comes from Ariel Hart with Atlanta Journal Constitution, your line is open.

ARIEL HART: Hi Dr. Frieden, first our governor is expected to announce Georgia's policy on quarantine and monitoring. Are you aware of it and do you have any reaction to it that's to come this afternoon? And the second question, given the national or even international implications of quarantine overkill that like you said could deter Ebola health care workers or deter full disclosure of history not to mention the civil liberty issues involved, what's the reasoning behind leaving it up to state to set their own quarantine policies? Does it make sense?

TOM FRIEDEN: First off, we look forward to working with Georgia and all states to get implemented, effected science-based policies for people who may have been exposed to Ebola. That's what today is guidelines are about, we've had discussions with the states and they've indicated that they will align their policies to our recommendations, and we are willing to work with any of the states to do what is science-based to protect Americans. We are concerned about policies that we've seen in various places that might have the effect of increasing stigma or creating false impressions. If you don't catch Ebola from someone who is not sick, you don't get Ebola from someone unless they're sick and you have direct contact with them or their body fluids. It's not nearly as contagious as the flu, the common cold, measles, or many other infectious diseases and we have to tailor our approach to the science of Ebola.

TOM SKINNER: Next question, Jennifer.

OPERATOR: The next question is comes from Rebecca Jacobson of CBS News Hour, your line is open.

REBECCA JACOBSON: Hi, thanks so much for taking my question, I'm actually with PBS, not CBS. I wanted to ask what is involved with, when you talk the active monitoring and at-home quarantine versus the kind of quarantine and isolation that somebody whose been

exposed to Ebola might face if they are actually, if they test positive for the disease?

TOM FRIEDEN: So it's very important for what's done with someone who may have or is confirmed to have Ebola. For that situation there is immediate isolation and protection, and then tracing of their contact. So anyone who has symptoms of Ebola, until they rule out, they would be isolated in a facility where they could be cared for without risking infection of their care givers. That's a different set of considerations. To my understanding, what Dr. Spencer did was when he began feeling ill, he arranged for special transport to the facility that was ready to care for Ebola patients. So that's one of the benefits of having the active monitoring program that you can prearrange with the individuals that if they do become sick, how are they going to seek care?

TOM SKINNER: Next question, Jennifer.

OPERATOR: The next is from Erika Edwards from NBC News, your line is open.

ERIKA EDWARDS: Hi, thank you. Editorial published today in the New England Journal of Medicine reads in part, we now know that fever proceeds the contagious stage. I was wondering if you could explain at what stage a person is contagious.

TOM FRIEDEN: In all of history until this outbreak, there were less than 3,000 cases of Ebola. In the current outbreak there have now been more than 10,000 cases of both including the first four ever diagnosed in this country. As we learn more about Ebola, we understand how it spreads, we understand how it presents, we understand how to treat it, and we understand what can be done to prevent and control it better. What happens as someone begins to become ill with Ebola is they develop an increase in symptoms, early on in the course of their disease, tests for Ebola, such as a blood test may be negative because there is such a tiny quantity of virus in their body. And negative test is very likely to correlate with that individual not being infectious to others. As people get sicker they develop fever and particularly if they develop vomiting or diarrhea, later in the course of their illness, there may be large quantities of the virus in their body fluids. And that's where the real risk comes in. It isn't as if they're going to be completely healthy and the next emanating huge quantities of infectious virus top to everything we have seen, it does not happen that way.

TOM SKINNER: Next question, Jennifer.

OPERATOR: The next question is from Lena Sun of the Washington Post, your line is open.

LENA SUN: Hi dr. Frieden, thanks for taking the questions. I have two, one is about the numbers. Of those 46 health care workers that have been, that fall in the category, can you characterize them in any way? Are they being actively monitored? Did they include some of the individuals who've already been mentioned in the numbers? And then the second question is, for those other states who you said are working with you, could you amplify on that a little bit since states have gone out on a limb and announced policies that are more strict than CDC guidelines?

TOM SKINNER: yes, in fact you know, this is a program that began as I mentioned on the 11th of October at JFK and the other four airports on the 16th of October, so it's relatively

recent. Dr. Spencer did go through the screening program, did self-identify as a health care worker, did not have a fever there; was assessed. The five-year-old did go through the screening program, did not have a fever when they entered the country. So the program, the information has been provided to each of the states, and the monitoring is as per the policies of that state. As of now, we have very specific guidance to states and we're working with them to help them implement that guidance. In terms of the different state policies, i believe that Maryland has issued policies that are quite similar, and we are in active discussions with the other states.

LENA SUN: Well, other states as the rest of the, you know, how many are we talking about?

TOM FRIEDEN: Well, actually, 70 percent the returning individuals from the three countries come to six states, Maryland is second most common, New York is the most, Pennsylvania, Georgia, New Jersey, and Virginia together account for 70 percent of the individuals who are returning. Most of whom I would remind people are U.S. citizens or legal permanent residents.

LENA SUN: Thank you.

TOM SKINNER: Next question, Jennifer.

OPERATOR: The next question comes from Donna Young of Scripp News, your line is open.

DONNA YOUNG: Thank you Dr. Frieden. I had a question, first of all when you went to West Africa on your visit, what guidelines did you follow yourself? And then also, are your guidelines similar to doctors without borders or because within their guidelines, they actually advise their health care workers to stay home for the 21 day incubation period. So can you kind of explain how many the CDC's guidelines are similar or differ, thank you.

TOM FRIEDEN: We work closely with doctors without borders. Their guidelines give a general recommendation that is consistent with the guidelines that we're issuing. Our guidelines are directed for state and local, public health agencies, but we along with our colleagues at USID have been working closely with all of the non-governmental organizations that send people to Africa and are looking forward to helping collaborate with state and local health departments to ensure there's a smooth process for returning to this country. In terms of myself, my 21 day period is long over, and i did not have symptoms during that period. I monitored my symptoms regularly. I didn't have any, if I had, I would have taken appropriate action.

TOM SKINNER: Next question, Jennifer.

OPERATOR: The next question is from Robert Lowes of Medscape, your line is open.

ROBERT LOWES: Yes, Dr. Frieden, thanks for taking my call. I guess in terms of the highest risk level of health care worker, in terms of just the terminology, you're talking about a voluntary quarantine, right? As opposed to, you know, people have referred to it as isolation, but you're talking about a voluntary at-home quarantine, is that correct?

TOM FRIEDEN: You're talking about for the high-risk individuals?

ROBERT LOWES: Yes, right, like who gets a needle stick.

TOM FRIEDEN: Yes, for those individuals we first are strongly recommending direct active monitoring. So someone is actually monitoring their health and their temperature on a daily basis. We also recommend that the public health authority ensures, through orders if necessary, but voluntary is usually acceptable that there would be, they wouldn't be going on public conveyances, planes, trains, buss, they wouldn't go to public places, shopping centers and movie theaters, wouldn't go to gatherings or workplaces, although of course they could telework, but there are activities that could proceed, such as jogging in a park. We would also for those individuals implement federal travel restrictions known as do the not board requirement which prevents people from flying in that circumstance. If people want to travel, that would have to be done by non-commercial conveyance, such as a car. It would have to be coordinated with the public health authority at both the origin and the destination so that there would be uninterrupted direct active monitoring.

TOM SKINNER: We'll take two more questions, please.

OPERATOR: Okay, the next question is from Kerry Sheridan of AFP, your line is open.

KERRY SHERIDAN: Thanks for taking my question. I was wondering if you could clarify for me, weren't there guidelines from the CDC before on this topic? And if so, how have the current guidelines changed, is there any specific you can point to that's changed, or is this the first time the CDC's issued this sort of guideline?

TOM FRIEDEN: There were prior guidelines and these are more specific, they're more focused. They provide a different risk categorization so they can provide more useful and clear input to state and local authorities, and they define with greater level of specificity both the risk levels and the public health actions that will be taken in different situations.

KERRY SHERIDAN: Okay thanks.

TOM SKINNER: Last question, Jennifer.

OPERATOR: The final question is from Delthia Ricks with Newsday. Your line is open.

DELTHIA RICKS: Thank you very much, Dr. Frieden. There have been so many problems that i'm hearing in the news and interviews that I'm doing of people who think this is extraordinarily contagious. On the level of the 1918 flu. You mentioned earlier it's not as con dangerous as the flu, the common cold, or measles, can you just go over that again very clearly and very explicitly so i can put it in a story and have these crazy people stop calling me.

TOM FRIEDEN: Thank you very much. I understand that people are afraid, Ebola is unfamiliar, it is a severe disease, but it is not highly contagious. And it requires direct contact with someone who is sick from Ebola or with their body fluids. I mentioned at the outset of this briefing, a classic study done by the CDC in Africa where people were living together in

hopes or huts, and of 78 household contacts of patients with confirmed Ebola, many of whom did not get isolated until they had pretty advanced disease, zero who did not have direct contact with the individual became infected. In health care, we have a saying, never say never, we are very clear that we're still assessing the situation, and with the outbreak continuing in Africa, it is still possible that people will come to this country and be diagnosed with Ebola. We still have health care workers being monitored who were caring for patients in Texas, we still have the individuals who were contacts of the New York City patient being monitored in New York City. So we're not out of the woods, but, the science is very clear. That catching Ebola requires direct contact with someone who is ill. And from our decades of experience fighting Ebola in Africa, we have not seen any outbreaks. We have not seen any spread that is from contact with someone before they became ill. We have not seen spread from two people who have not had that kind of direct contact. So just to recap, i want to thank everyone for joining us; we have new guidelines that are being posted today. They increase the level of protection of the health and safety of Americans which is our first and foremost priority while at the same time, protecting those who are doing the heroic work of protecting us from Ebola as they fight it on the shores of Africa as well.

TOM SKINNER: Thank you, Jennifer, this concludes our call today. For media on the call, we should be sending out these guidelines eminently to our media list through e-mail and posting to our website. So you should be receiving those if you haven't already. If you have additional questions, call 404-639-3286. Thank you.

OPERATOR: This concludes today's conference, thank you for your attendance, you may disconnect at this time.

###
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES