Academy (Table). Of these specimens, 12 (41%) were P1 type 1, 15 (52%) were P1 type 2a, and only 2 (7%) were P1 type 2c. A polyclonal distribution with 8 distinct MLVA types was observed, with the MLVA type M representing 11 (38%) of the identified MLVA types. Without the MPN1 marker, 3 MLVA types were observed. No macrolide resistance–associated mutation was detected, similar to what was observed in the 32 specimens collected in 2013. This finding is consistent with the low prevalence of macrolide resistance reported in northern Europe (6,7).

We report 2 outbreaks of *M. pneumoniae* infections that occurred in the first and last quarter of 2013 in western Russia (Smolensk region). Despite the high predominance of P1 type 1 strains reported in the recent literature (1,2,7), these 2 outbreaks, reported in semiclosed settings involved only the newly described P1 type 2c variant; 1 outbreak represented a monoclonal phenomenon. In the Smolensk region, the circulation of both type 1 and 2 strains was observed a few years before the outbreak; most of these strains were P1 type 2a variants, and only a minority were type 2c variants, suggesting that the new type 2c variant had spread throughout this region of Russia since at least 2006. In other parts of the world, a switch between type 1 and type 2 strains might be occurring. Indeed, in the United States, P1 type 1 isolates predominated before 2010 but dropped to 50% of isolates in 2013, and type 2 and type 2 variant strains increased (9). This cyclic pattern of type 1 or type 2 predominance in the population has previously been reported (10).

In conclusion, we detected no macrolide resistance in western Russia. The P1 type 2c variant spread throughout this region and can be responsible for monoclonal outbreaks. The epidemiologic monitoring of *M. pneumoniae* P1 types will assess the potential switch to P1 type 2 in the United States and other parts of the world and detect the possible emergence of the P1 type 2c variant. This study was supported by internal funding.

References


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Initial Costs of Ebola Treatment Centers in the United States


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To the Editor: The 2014–2015 outbreak of Ebola virus disease (EVD) in West Africa was unprecedented in scale and scope. During the outbreak, 11 patients with
EVD were cared for in the United States (1). Safely caring for patients with suspected EVD requires specialized protocols and training for hospital staff in the use of personal protective equipment (PPE) and isolation precautions (2,3). The care of a hospitalized patient with confirmed EVD in high-level isolation units requires large specialized teams of nurses, physicians, laboratory technologists, environmental service workers, and waste management specialists, and inpatient care may continue for weeks (3,4). The staff-to-patient ratio necessary to care for a patient with EVD in high-level isolation is much higher than that in a typical intensive care unit because of the extensive PPE used and the need for partners to assist with PPE donning and doffing.

In response to preparedness challenges in the United States, the Centers for Disease Control and Prevention recommended a multitiered framework of hospitals with advanced capabilities for Ebola care: frontline facilities, Ebola assessment hospitals, and Ebola treatment centers (ETCs) (2). Within this federal framework, 55 hospitals in the United States have been designated by their states as ETCs, which have the advanced capabilities required to provide medical care to patients with confirmed EVD throughout their illness (5). Although the cost of preparing these healthcare facilities to care for EVD patients was believed to be substantial (5–7), we aimed to directly survey the ETCs to determine the costs incurred to prepare their facilities to manage and treat EVD patients.

In April 2015, we sent a 19-question electronic survey to all 55 ETCs, including the 3 preexisting biocontainment patient care units (online Technical Appendix, http://wwwnc.cdc.gov/EID/article/22/2/15-1431-Techapp1.pdf). Participation was voluntary, and individual responses were confidential. The survey assessed the ETCs' general competencies for high-level patient isolation centers. The Institutional Review Board of the University of Nebraska Medical Center declared this study exempt.

Of the 55 ETCs, 47 (85.5%) responded to the survey; 45/47 reported the total costs incurred to establish their ETC, and 43/47 provided a detailed assessment of costs. The 45 ETCs reporting total costs incurred a cumulative total of $53,909,701 (mean $1,197,993/ETC) to establish the ETCs (Table). The most costly activity was facility construction and modifications. Costs incurred to provide initial training for staff averaged $267,075 (range $10,000–$1,624,639). Each ETC spent $172,581 (mean per facility; range $3,000–$560,000) on other expenses not included in the 5 specified categories (Table). Examples of additional costs included computer hardware and software, nonmedical equipment, office supplies, and employee apparel. Costs and expenses allocated to specific purchases varied by region (online Technical Appendix Figures 1, 2).

With the exception of 3 hospitals that had preexisting biocontainment units, 52 hospitals had to undertake novel activities to prepare to care for patients with EVD, including development of plans, recruitment of facility leadership, recruitment and training of a multidisciplinary team of volunteers, and purchase of specialized supplies and equipment. The nearly $54 million in previously un-budgeted expenses was a substantial financial burden on the ETCs. Wide variations for overall expenditures and for specific types of expenditures were noted.

Because 10 ETCs did not report financial data, the overall costs reported here do not fully estimate the expenses incurred by ETCs. Furthermore, these overall costs represent only the initial start-up costs of establishing ETCs and do not include the costs of ongoing maintenance such as resupplying validation reagents for the laboratory, purchasing supplies and equipment, continual training of staff, or testing the units and programs.

This study had limitations. We could not validate self-reported data from the ETCs with information from expense reports. We also acknowledge that many additional hospitals undertook similar efforts to those of the designated ETCs but were not included in this survey (8). The costs incurred by public and private public health organizations also were not included.

In conclusion, we have described the initial preparation costs incurred by designated ETCs in the United States. The substantial start-up costs as well as ongoing maintenance costs of EVD programs underscore the need for special

### Table. Initial costs in US$ incurred by 45 Ebola treatment centers in the United States*

<table>
<thead>
<tr>
<th>Cost scale</th>
<th>Total costs</th>
<th>Construction/ facility modifications</th>
<th>PPE supplies</th>
<th>Staff training</th>
<th>Unit planning</th>
<th>Laboratory equipment</th>
<th>Non-PPE and nonlaboratory supplies and equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average</td>
<td>1,197,993</td>
<td>420,502</td>
<td>213,347</td>
<td>267,075</td>
<td>176,713</td>
<td>99,106</td>
<td>172,581</td>
</tr>
<tr>
<td>Median</td>
<td>1,000,000</td>
<td>202,980</td>
<td>110,000</td>
<td>150,000</td>
<td>82,000</td>
<td>84,000</td>
<td>100,000</td>
</tr>
<tr>
<td>High</td>
<td>6,596,457</td>
<td>3,839,000</td>
<td>1,067,573</td>
<td>1,624,639</td>
<td>1,200,000</td>
<td>317,406</td>
<td>560,000</td>
</tr>
<tr>
<td>Low</td>
<td>51,500</td>
<td>8,500</td>
<td>10,000</td>
<td>10,000</td>
<td>10,000</td>
<td>15,000</td>
<td>3,000</td>
</tr>
<tr>
<td>Sum†</td>
<td>53,909,701</td>
<td>16,820,080</td>
<td>8,747,240</td>
<td>10,950,072</td>
<td>4,947,966</td>
<td>3,865,124</td>
<td>6,385,513</td>
</tr>
</tbody>
</table>

*PPE, personal protective equipment.
†Summarized data were collected through self-report by individual treatment centers through an electronically administered survey.
facilities to treat EVD (9,10). A tiered nationwide network of healthcare facilities that can rapidly identify, isolate, and treat patients with EVD has been established to improve the nation’s preparedness for EVD and can serve as a valuable resource for future outbreaks of other highly infectious diseases. Ongoing resources will be needed to sustain the readiness of such a network.

References


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Detection of Influenza D Virus among Swine and Cattle, Italy

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To the Editor: Recent studies have identified a new genus of the Orthomyxoviridae family (1–5). The virus, distantly related to human influenza C virus, has been provisionally designated as influenza D virus. This novel virus was identified for the first time in pigs with influenza-like illness (I), but subsequent serologic and virologic surveys have suggested cattle as a possible reservoir (2–4). Moreover, the virus was shown to infect ferrets used in laboratories as surrogates for humans when investigating influenza infection (I). In a serologic study conducted on 316 human samples, low antibody titers and a low level of positive samples (1.3%) were detected (I), suggesting that humans are a possible host to be studied in depth. To investigate the circulation of influenza D viruses among pigs and cattle in Italy, we performed biomolecular and virological tests on clinical samples collected from respiratory outbreaks in Po Valley, the area in Italy with the highest density of swine and cattle farms.

We screened clinical specimens from swine (n = 150) and cattle (n = 150) for influenza D virus by reverse transcription quantitative PCR (I). Three nasal swab samples were found positive: 1 from a sow and 2 from cattle, collected from 3 farms located at linear distances ranging from 47 to 80 km. All positive samples were confirmed by partial polymerase basic 1 gene sequencing and submitted to viral isolation in cell cultures as previously described (5,6). The virus was isolated on CACO-2 and HRT18 cell cultures only from the sow sample (D/swine/Italy/199723-3/2015). Cell cultures were tested by using reverse transcription quantitative PCR. Viral RNA was isolated from clinical samples or cell culture by using One-For-All Vet Kit (QIAGEN, Milan, Italy). Full-genome amplification from influenza D virus–positive samples was achieved as previously described (3). A sequencing library of the purified amplicons was prepared by using NEXTERA-XT kit and

1These authors contributed equally to this article.
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Technical Appendix

A.1 General Aspects. The facility addressed in this checklist:
A.1.a) Please indicate the name of the EVD/Special Pathogens Care Treatment sponsoring hospital and location:
Hospital: ____________________________ City/State: ____________________________
A.1.b) Is the hospital applying to be the regional center? □ YES □ NO
A.1.c) EVD inpatient care facility is located within:
   i) Main Hospital Building(s) □ YES □ NO
      If yes, Located within
         ☐ Academic/teaching hospital
         ☐ Referral/regional hospital (but not Academic Medical Center)
         ☐ Other (Armed Forces/Infectious Disease Center):
   ii) Independent facility (stand alone facility) □ YES □ NO
      If yes, is facility located on the same campus as main hospital building(s)? □ YES □ NO
      No information / other (please specify):

A.2. High level isolation Capacity:
A.2.a) Number of Ebola or Highly Infectious Disease ISOLATION ROOMS AND BEDS
   i) Maximum number of high level patient isolation rooms and beds that can be used simultaneously
      number of rooms: ____________________________ number of beds (total): ____________________________
      ii) Bed capacity for adult patients
         n = ____________________________
         Critical care capable? □ YES □ NO
      iii) Bed capacity for pediatric patients
         n = ____________________________
         Critical care capable? □ YES □ NO
      No information / other (please specify):

A.3. Location of isolation rooms
A.3.a) Where are the isolation rooms specifically located?
   i) In a separate ward, but within the same building as other main hospital facilities □ YES □ NO
      If yes, is the air handling for the ward separate from the air handling for the rest of the building?
      □ YES □ NO
   ii) In separate rooms, but in the same ward as other hospital facilities □ YES □ NO
      (e.g. Inf. Diseases Ward, or ICU)
      If yes, is there a physical barrier (wall or other) separating the isolation rooms from the rest of the ward?
      □ YES □ NO
      If yes, please describe the barrier: ____________________________

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If yes, is the air handling for the rooms separate from the air handling for the rest of the ward?

YES  NO

iii) No information / other (please specify):

B.1 Infrastructure features for infection control available

B.1.a) Use of Ante room/area adjacent to patient isolation room for doffing PPE  YES  NO

If yes, please specify:

i) Are the “Clean” entrance and “dirty” exit separated? (2 doors)  YES  NO

ii) Is the entrance/exit via same pathway (door)  YES  NO

No information / other (please specify):

B.1.b) Isolation unit layout

Are the entrance and exits to the unit separated (2 doors/paths)  YES  NO

i) Do the staff enter/exit via same pathway/door  YES  NO

ii) No information / other (please specify):

B.1.c) Are all of the EVD isolation rooms negative pressure patient isolation rooms  YES  NO

If yes, please specify

i) Number of air changes per hour __________________________ Quantity:__________________________

No information / other (please specify):

B.1.c) HEPA filtration  YES  NO

If yes, filtration of: intake air exhausted air both

No information / other (please specify):

B.1.d) On-site sterilization of medical waste  YES  NO

If yes, please specify

i) sterilization method: autoclave incinerator other

If yes, please specify

In the isolation unit itself

In the hospital elsewhere

If no, process identified for Category A Infectious Substance disposal  YES  NO

No information / other (please specify):
B.2 Laboratory capabilities of isolation facility

B.2.a) Location of laboratory support (Check all that apply)

i) Located within the patient care room  YES  NO
ii) Located within the isolation unit  YES  NO
iii) Located within the same campus  YES  NO
iv) Located within the same city  YES  NO
No information / other (please specify):

B.3.b) Classification of laboratory support (Check all that apply)

i) Bedside Point of Care Testing  YES  NO
ii) Clinical laboratory  YES  NO
iii) Public Health laboratory  YES  NO
No information / other (please specify):

B.3.c) Biosafety designation of hospital laboratory

i) BSL-2
ii) BSL-3
iii) BSL-4
No information / other (please specify):

B.3.c) Biosafety designation of public health laboratory

i) BSL-2
ii) BSL-3
iii) BSL-4
No information / other (please specify):

C.1 Cost of establishing high-level isolation capability

C.1.a) Approximate total cost incurred to establish ETC capacity since June, 2014: $________________________

Construction/facility modifications: $________________________
PPE purchases: $________________________
Staff training: $________________________
Unit planning: $________________________
Acquisition of lab testing equipment: $________________________
Other unit equipment purchases (not PPE or lab equipment): $________________________
D.1. Ebola treatment center consortium participation

D.1.a) Would your facility participate as a member in a consensus network of isolation units to establish infection control metrics, competencies, and peer review for high-level patient isolation centers? YES NO

If yes, please specify

Point of contact for consortium participation:
Name: __________________________
E-mail: __________________________

Survey sent to all Ebola Treatment Centers.

Technical Appendix Figure 1. Average total costs incurred in each of the 10 US Health and Human Services regions. Summarized data was collected through self-report by individual treatment centers through an electronically administered survey. ¹ All Region 8 Ebola treatment centers provided estimates
Technical Appendix Figure 2. Interquartile ranges of the distribution of costs of 45 Ebola treatment centers (US $). Data were collected through self-report by individual ETCs through an electronically-administered survey.