



Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

June 29, 2021

Austin Evers
American Oversight
1030 15th Street NW, Suite B255
Washington, DC 20005

FOIL #: 20-03-171

Dear Austin Evers:

This letter responds to your Freedom of Information Law (FOIL) request of March 11, 2020, in which you requested the following:

All email communications (including emails, email attachments, and calendar invitations) [from January 31, 2020, through March 1, 2020] between 1) Commissioner of Health Howard A. Zucker, anyone serving as his chief of staff or in a similar position, and anyone in the Commissioner's office tasked with or responsible for communicating with federal health authorities regarding the COVID-19 outbreak, and 2) the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the Department of Health and Human Services (HHS), or the Executive Office of the President (EOP) (individuals communicating from these federal entities have email addresses ending in, respectively, cdc.gov, fda.gov, hhs.gov, and eop.gov), that contain any of the following key terms:

- a) Test
- b) Testing
- c) coronavirus
- d) "COVID-19"
- e) "SARS-cov-2"
- f) "2019-nCoV"
- g) EUA
- h) "Emergency Use Authorization"
- i) Kit
- j) LDT
- k) CLIA
- l) Wadsworth
- m) Epidemic
- n) Pandemic
- o) Wuhan
- p) Hubei

I have enclosed documents responsive to your request. Certain information contained in these records has been redacted and certain documents have been withheld pursuant to New York State Public Officers Law §87(2)(b), because disclosure “would constitute an unwarranted invasion of personal privacy;” §87(2)(g), as “inter-agency or intra-agency materials;” §87(2)(i), to “guarantee the security of . . . information technology assets;” and to remove non-remove material.

Should you feel that you have been unlawfully denied access to records, you may appeal such denial in writing within 30 days to the Records Access Appeals Officer, Division of Legal Affairs, Empire State Plaza, 2438 Corning Tower, Albany, New York 12237-0026.

If you require additional information or wish to discuss this matter further, please do not hesitate to contact me at (518) 474-8734.

Sincerely,

Rosemarie Hewig

Rosemarie Hewig, Esq.
Records Access Officer

RH/bae

From: [Centers for Disease Control and Prevention](#)
To: [Dreslin, Sally R \(HEALTH\)](#)
Subject: CDC HAN 428: Update and Interim Guidance on Outbreak of Coronavirus Disease 2019 (COVID-19)
Date: Friday, February 28, 2020 6:25:12 PM

ATTENTION: This email came from an external source. Do not open attachments or click on links from unknown senders or unexpected emails.

CDC issued the following Health Alert Network (HAN) Health Update on February 28, 2020. You are receiving this information because you subscribe to COCA email updates. If a colleague forwarded this email to you, yet you would like to receive future updates directly from COCA, [click here](#).

If you have any questions about this or other clinical issues, please e-mail coca@cdc.gov

On behalf of the Clinician Outreach and Communication Activity (COCA)
Centers for Disease Control and Prevention (CDC)
Join us on [Facebook](#)

HAN - this is an official CDC Health Update



Distributed via the CDC Health Alert Network
February 28, 2020, 1505 ET (3:05 PM ET)
CDCHAN-00428

Update and Interim Guidance on Outbreak of Coronavirus Disease 2019 (COVID-19)

Summary

The Centers for Disease Control and Prevention (CDC) continues to closely monitor and respond to the COVID-19 outbreak caused by the novel coronavirus, SARS-CoV-2.

This CDC Health Alert Network (HAN) Update provides updated guidance on evaluating and testing persons under investigation (PUIs) for COVID-19. It supersedes guidance

provided in CDC's HAN 427 distributed on February 1, 2020.

The outbreak that began in Wuhan, Hubei Province, has now spread throughout China and to 46 other countries and territories, including the United States. As of February 27, 2020, there were 78,497 reported cases in China and 3,797 cases in locations outside China. In addition to sustained transmission in China, there is evidence of community spread in several additional countries. CDC has updated travel guidance to reflect this information (<https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html>).

To date, there has been limited spread of COVID-19 in the United States. As of February 26, 2020, there were a total of 61 cases within the United States, 46 of these were among repatriated persons from high-risk settings. The other 15 cases were diagnosed in the United States; 12 were persons with a history of recent travel in China and 2 were persons in close household contact with a COVID-19 patient (i.e. person-to-person spread). One patient with COVID-19 who had no travel history or links to other known cases was reported on February 26, 2020, in California. The California Department of Public Health, local health departments, clinicians, and CDC are working together to investigate this case and are identifying contacts with whom this individual interacted.

CDC, state and local health departments, other federal agencies, and other partners have been implementing measures to slow and contain transmission of COVID-19 in the United States. These measures include assessing, monitoring, and caring for travelers arriving from areas with substantial COVID-19 transmission and identifying cases and contacts of cases in the United States.

Recognizing persons at risk for COVID-19 is a critical component of identifying cases and preventing further transmission. With expanding spread of COVID-19, additional areas of geographic risk are being identified and PUI criteria are being updated to reflect this spread. To prepare for possible additional person-to-person spread of COVID-19 in the United States, CDC continues to recommend that clinicians and state and local health departments consider COVID-19 in patients with severe respiratory illness even in the absence of travel history to affected areas or known exposure to another case.

Criteria to Guide Evaluation and Testing of Patients Under Investigation (PUI) for COVID-19

Local or state health departments, in consultation with clinicians, should determine whether a patient is a PUI for COVID-19. The CDC clinical criteria for COVID-19 PUIs have been developed based on available information about this novel virus, as well as what is known about Severe Acute Respiratory Syndrome (SARS) (<https://www.cdc.gov/sars/clinical/guidance.html>) and Middle East Respiratory Syndrome (MERS) (<https://www.cdc.gov/coronavirus/mers/interim-guidance.html#evaluation>). These criteria are subject to change as additional information becomes available.

Clinical Features		Epidemiologic Risk
Fever ¹ or signs/symptoms of lower respiratory illness (e.g., cough or shortness of breath)	AND	Any person, including healthcare personnel ² , who has had close contact ³ with a laboratory-confirmed ⁴ COVID-19 patient within 14 days of symptom onset
Fever ¹ and signs/symptoms of a lower respiratory illness (e.g., cough	AND	A history of travel from affected geographic areas ⁵ , within 14 days of symptom onset

or shortness of breath) requiring hospitalization		
Fever ¹ with severe acute lower respiratory illness (e.g., pneumonia, ARDS (acute respiratory distress syndrome) requiring hospitalization and without an alternative explanatory diagnosis (e.g., influenza). ⁶	AND	No identified source of exposure

These criteria are intended to serve as guidance for evaluation. In consultation with public health departments, patients should be evaluated on a case-by-case basis to determine the need for testing. Testing may be considered for deceased persons who would otherwise meet the PUI criteria.

¹Fever may be subjective or confirmed.

²For healthcare personnel, testing may be considered if there has been exposure to a person with suspected COVID-19 without laboratory confirmation. Because of their often extensive and close contact with vulnerable patients in healthcare settings, even mild signs and symptoms (e.g., sore throat) of COVID-19 should be evaluated among potentially exposed healthcare personnel. Additional information is available in CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>).

³Close contact is defined as—

a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case

— or —

b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)

If such contact occurs while not wearing recommended personal protective equipment (PPE) (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.

Additional information is available in CDC's updated Interim Healthcare Infection Prevention and Control Recommendations for Patients with Confirmed COVID-19 or Persons Under Investigation for COVID-19 in Healthcare Settings (<https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>).

Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g., coughing likely increases exposure risk, as does exposure to a severely ill patient). Special consideration should be given to healthcare personnel exposed in healthcare settings, as described in

CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with COVID-19 (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>).

⁴Documentation of laboratory-confirmation of COVID-19 may not be possible for travelers or persons caring for COVID-19 patients in other countries.

⁵Affected areas are defined as geographic regions where sustained community transmission has been identified. Relevant affected areas will be defined as a country with at least a CDC Level 2 Travel Health Notice. Current information is available in CDC's COVID-19 Travel Health Notices (<https://www.cdc.gov/coronavirus/2019-ncov/travelers>).

⁶Category includes single or clusters of patients with severe acute lower respiratory illness (e.g., pneumonia, ARDS (acute respiratory distress syndrome) of unknown etiology in which COVID-19 is being considered.

Recommendations for Reporting, Testing, and Specimen Collection

Clinicians should immediately implement recommended infection prevention and control practices (<https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>) if a patient is suspected of having COVID-19. They should also notify infection control personnel at their healthcare facility and their state or local health department if a patient is classified as a PUI for COVID-19. State health departments that have identified a PUI or a laboratory-confirmed case should complete a PUI and Case Report form through the processes identified on CDC's Coronavirus Disease 2019 website (<https://www.cdc.gov/coronavirus/2019-ncov/php/reporting-pui.html>). State and local health departments can contact CDC's Emergency Operations Center (EOC) at 770-488-7100 for assistance with obtaining, storing, and shipping appropriate specimens to CDC for testing, including after hours or on weekends or holidays. Currently, diagnostic testing for COVID-19 is being performed at state public health laboratories and CDC. Testing for other respiratory pathogens should not delay specimen testing for COVID-19.

For initial diagnostic testing for SARS-CoV-2, CDC recommends collecting and testing upper respiratory tract specimens (nasopharyngeal AND oropharyngeal swabs). CDC also recommends testing lower respiratory tract specimens, if available. For patients who develop a productive cough, sputum should be collected and tested for SARS-CoV-2. The induction of sputum is not recommended. For patients for whom it is clinically indicated (e.g., those receiving invasive mechanical ventilation), a lower respiratory tract aspirate or bronchoalveolar lavage sample should be collected and tested as a lower respiratory tract specimen. Specimens should be collected as soon as possible once a PUI is identified, regardless of the time of symptom onset. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Patients Under Investigation (PUIs) for COVID-19 (<https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html>) and Biosafety FAQs for handling and processing specimens from suspected cases and PUIs (<https://www.cdc.gov/coronavirus/2019-ncov/lab/biosafety-faqs.html>).

For More Information

More information is available at the COVID-19 website:
<https://www.cdc.gov/coronavirus/2019-ncov/index.html>.

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by

preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

Categories of Health Alert Network messages:

Health Alert - Requires immediate action or attention; highest level of importance

Health Advisory - May not require immediate action; provides important information for a specific incident or situation

Health Update - Unlikely to require immediate action; provides updated information regarding an incident or situation

HAN Info Service - Does not require immediate action; provides general public health information

##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##

You have received this message based upon the information contained within our emergency notification data base. If you have a different or additional e-mail or fax address that you would like us to use please contact your State-based Health Alert Network program at your State or local health department.



Centers for Disease Control and Prevention

1600 Clifton Rd Atlanta, GA 30329 1-800-CDC-INFO (800-232-4636) TTY: 888-232-6348

[Questions or Problems](#) | [Unsubscribe](#)

From: [Centers for Disease Control and Prevention](#)
To: [Dreslin, Sally R \(HEALTH\)](#)
Subject: CDC COCA Call: Coronavirus Disease 2019 (COVID-19) Update—What Clinicians Need to Know to Prepare for COVID-19 in the United States
Date: Friday, February 28, 2020 12:58:32 PM

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COCA Call - CDC Clinician Outreach and Communication Activity



Coronavirus Disease 2019 (COVID-19) Update— What Clinicians Need to Know to Prepare for COVID-19 in the United States

Overview

During this COCA Call, clinicians will learn what they can do to prepare for COVID-19 including identifying persons under investigation, applying infection prevention and control measures, assessing risks for exposures, optimizing the use of personal protective equipment supplies, and managing and caring for patients (inpatient and at home).

Special Request: Due to the high demand we anticipate for this COCA Call, we kindly ask participants to access it in a group format, if possible, to allow for the maximum number of people to participate.

Watch on Facebook: You may also participate in this COCA Call by joining COCA's [Facebook Live](#).

Advanced registration is not required.

Continuing Education will not be offered for this COCA Call.

Coronavirus Disease 2019 illustration



Date: Thursday, March 5, 2020

Time: 2:00pm–3:00pm (ET)

Please click the link below to join:

<https://zoom.us/j/695903771>

Or iPhone one-tap:

US: +16468769923,,695903771# or
+16699006833,,695903771#

Or Telephone:

US: +1 646 876 9923 or +1 669 900 6833

Webinar ID: 695 903 771

International numbers available:

<https://zoom.us/u/anixAVglV>

If you are unable to attend this live COCA Call, it will be available to view [on-demand](#) a few hours after the call.

Presenters

Sue Gerber, MD

COVID-19 Response Epidemiology Task Force Deputy Lead
National Center for Immunization and Respiratory Diseases
Centers for Disease Control and Prevention

Amber M. Vasquez, MD, MPH

COVID-19 Response Infection Prevention and Control Team

National Center for Emerging and Zoonotic Infectious Diseases
Centers for Disease Control and Prevention

CAPT Lisa Delaney, MS, CIH (USPHS)

COVID-19 Response Worker Health and Safety Team
National Institute for Occupational Safety and Health
Centers for Disease Control and Prevention

Angela J. P. Campbell, MD, MPH, FPIDS, FIDSA

COVID-19 Response Clinical Team
National Center for Immunization and Respiratory Diseases
Centers for Disease Control and Prevention

CDC Resources

- [Evaluating and Reporting Persons Under Investigation \(PUI\)](#)
- [Healthcare Infection Control Guidelines](#)
- [Healthcare Personnel with Potential COVID-19 Exposure](#)
- [Strategies for Optimizing Supply of N95 Respirators](#)
- [Clinical Care Guidance](#)
- [Implementing Home Care of People Not Requiring Hospitalization](#)
- [Disposition of Non-Hospitalized Patients with COVID-19](#)
- [Interim Guidance for Collection and Submission of Postmortem Specimens from Deceased Persons Under Investigation \(PUI\) for COVID-19, February 2020](#)

The Emergency Risk Communication Branch in the Division of Emergency Operations, Center for Preparedness and Response is responsible for the management of all COCA products.

For information about this update or other clinical issues, or to send your feedback, please contact us at coca@cdc.gov

- [CDC Clinician Outreach and Communication Activity Facebook page](#)—connect with COCA on Facebook
- [Clinician Outreach and Communication Activity](#)—resources for healthcare providers
- [COCA RSS Feed](#)—subscribe to be notified of conference calls, updates, and CDC guidance for health providers
- [Crisis & Emergency Risk Communication Training](#)—training program that draws from lessons learned during public health emergencies, and incorporates best practices from the fields of risk and crisis communication

- [Health Alert Network](#)—CDC's primary method of sharing cleared information about urgent public health incidents with public information officers; federal, state, territorial, and local public health practitioners; clinicians; and public health laboratories

CDC Logo



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Centers for Disease Control and Prevention

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From: Greene, Danielle (HEALTH)
Sent: Wednesday, February 26, 2020 11:41 AM
To: CDC IMS State Coordination Task Force (SCTF) Operations
Subject: Accepted: COVID-19 Public Health Response Operations

From: [Susan Schulz](#)
To: [King, Brian a. \(CDC/DDNID/NCCDPHP/OSH\)](#); [Layden, Jennifer E.](#); [Zucker, Howard A \(HEALTH\)](#); [Dawkins, Edna \(CDC/DDNID/NCCDPHP/OSH\) \(CTR\)](#); [Silvia, Jacqueline S \(HEALTH\)](#); [Alexandra Loukas](#); [Sutton, Barbara \(HEALTH\)](#)
Cc: [Barbara Knappmeyer](#)
Subject: Organizers of Vaping: Please forward this email to your network.
Date: Wednesday, February 26, 2020 11:07:08 AM
Attachments: [4 2-3 20 Vaping - Flyer SS2.pdf](#)
[Youth Vaping Epidemic 2020 Social Toolkit.docx](#)

ATTENTION: This email came from an external source. Do not open attachments or click on links from unknown senders or unexpected emails.

Hello, Organizers of our Youth Vaping Epidemic events,

See below email that we sent out yesterday; I thought it would be helpful for you to have this so you could easily forward it to people in your network who might be interested in attending.

If any of you are active on social media, please retweet this recent tweet that promotes the evening panel event: <https://twitter.com/NYASciences/status/1232372198167453698>

We'll be posting on social about the daytime symposium again soon and I'll forward that tweet for you to amplify as well. You can also access our social media toolkit, attached, which has social cards and language to use.

Let me know if you have any questions and thanks so much for helping to spread the word!

Best,

Susan

Susan Schulz
Marketing Director
New York Academy of Science
212.298.3744
sschulz@nyas.org

From: Barbara Knappmeyer, PhD, New York Academy of Sciences <nyas@nyas.org>
Sent: Wednesday, February 26, 2020 10:51 AM
To: Susan Schulz <sschulz@nyas.org>
Subject: Join Me for Special Events on the Youth Vaping Epidemic



[View in Browser](#)



Join Us for One or Both of These Important Events



LOCATION: New York Academy of Sciences, 7 World Trade Center, NYC

Dear Colleague,

This is a reminder about two important events taking place on April 2nd and 3rd addressing the public health issues around vaping.

On Thursday evening, April 2nd, [Vaping: Fact Versus Fiction](#), a panel discussion, open to the public, will address the addictive nature of vaping especially among teens, the potential health consequences of long-term vaping, and the best approaches to protect our young people from this dangerous trend. Learn more and register at nyas.org/VapeFacts2020.

On Friday, April 3rd, a full-day scientific symposium, [The Youth Vaping Epidemic: From Science to Public Policy](#), will convene experts from academic, clinical, public health, and policy communities to focus on how emerging science can support evidence-based policy recommendations to contain this growing epidemic. Learn more and register at nyas.org/VapeSci20.

I hope you'll join us for one or both of these important events and that you'll spread the word about them to scientific colleagues who may also be interested in attending, as well as teachers and school nurses in your school district.

Thank you.

Sincerely,

Barbara Knappmeyer, PhD

Program Manager

New York Academy of Sciences

[REGISTER](#)



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APR
2
2020

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3
2020



The Youth Vaping Epidemic: What You Need to Know

➔ **Register at nyas.org/VapeFacts2020** (April 2nd, panel event)

➔ **Register at nyas.org/VapeSci20** (April 3rd, scientific symposium)

Please join us for one or both of these important events coming up in April:

Vaping: Fact Versus Fiction

April 2nd, 6:30 p.m. – 8:15 p.m.

This panel discussion, open to the public, will address important topics such as the addictiveness of vaping, the health consequences of vaping, and whether bans are the most effective way to contain the vaping epidemic.

The Youth Vaping Epidemic: From Science to Public Policy

April 3rd, 8:30 a.m. – 5:00 p.m.

This daylong scientific symposium will convene experts from academic, clinical, public health, and policy communities to discuss new approaches for the prevention of teen vaping.

Location

The New York Academy of Sciences
7 World Trade Center
250 Greenwich Street
40th Floor
New York, NY 10007

 @NYASciences
#VapeFacts2020
#VapeSci20

Organizers

Brian King, PhD, MPH
Centers for Disease Control
and Prevention (CDC)

Jennifer Layden, MD
Illinois Department of Public Health

Alexandra Loukas, PhD
The University of Texas at Austin

Howard Zucker, MD, JD
New York State Department
of Health

Sonya Dougal, PhD
New York Academy of Sciences

Barbara Knappmeyer, PhD
New York Academy of Sciences

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The Youth Vaping Epidemic: What You Need to Know

➔ **Register at nyas.org/VapeFacts2020** (April 2nd, panel event)

➔ **Register at nyas.org/VapeSci20** (April 3rd, scientific symposium)

Vaping: Fact Versus Fiction

April 2nd, 6:30 p.m. – 8:15 p.m.

Speakers

Meredith Berkman

Parents Against Vaping e-Cigarettes

Bonnie Halpern-Felsher, MD

Stanford University

Steve Kelder, PhD

The University of Texas at Austin
and Coordinated Approach to Child
Health (CATCH)

Howard Zucker, MD, JD

New York State Department
of Health

The Youth Vaping Epidemic: From Science to Public Policy

April 3rd, 8:30 a.m. – 5:00 p.m.

Speakers

Bonnie Halpern-Felsher, MD

Stanford University

Steve Kelder, PhD

The University of Texas at Austin
and Coordinated Approach to Child
Health (CATCH)

Suchitra Krishnan-Sarin, PhD

Yale School of Medicine

Frances Leslie, PhD

University of California, Irvine

Rachel Grana Mayne, PhD, MPH

National Cancer Institute

Matthew Myers

Campaign for Tobacco-Free Kids

Donna Vallone, PhD, MPH

The Truth Initiative, New York
University



Social Toolkit

The Youth Vaping Epidemic: From Science to Public Policy

Friday, April 3, 2020

Event Description: The current youth vaping epidemic highlights the urgent need to understand the science and health effects of vaping. This symposium will convene experts from academic, clinical, and public health communities to discuss the science of vaping and related public policy recommendations.

Event Link & Registration: nyas.org/VapeSci20

Event Hashtag: #VapeSci20

Public Evening Event (April 2) Trello Toolkit: <https://trello.com/b/7FuHliwC/vaping-fact-versus-fiction>

Twitter: twitter.com/NYASciences

Facebook: facebook.com/nyasciences

LinkedIn: linkedin.com/company/new-york-academy-of-sciences/

I. EARLY BIRD DEADLINE POSTS

Suggested Twitter post:

The early bird deadline for the @NYASciences #VapeSci20 daylong meeting is Friday, February 21st. Register soon to save 30%: <https://bit.nyas.org/2OtnL3F>

Suggested Facebook / LinkedIn post:

The early bird deadline for the New York Academy of Sciences' "Youth Vaping Epidemic" symposium is Friday, February 21st. Register soon to save 30%: <https://bit.nyas.org/2OtnL3F>

Early Bird Deadline Social Card:

#VapeSci20

**EARLY BIRD
Discount Ends
Feb 21!**

The Youth Vaping Epidemic: From Science to Public Policy

April 3, 2020

nyas.org/VapeSci20



II. GENERAL POSTS

Suggested Twitter post:

Join the @NYASciences on April 3rd for a symposium convening academic, public health + policy communities to discuss the emerging science behind the youth #vaping epidemic and learn about evidence-based policy recommendations. Register here:

<https://bit.nyas.org/2OtnL3F> #VapeSci20

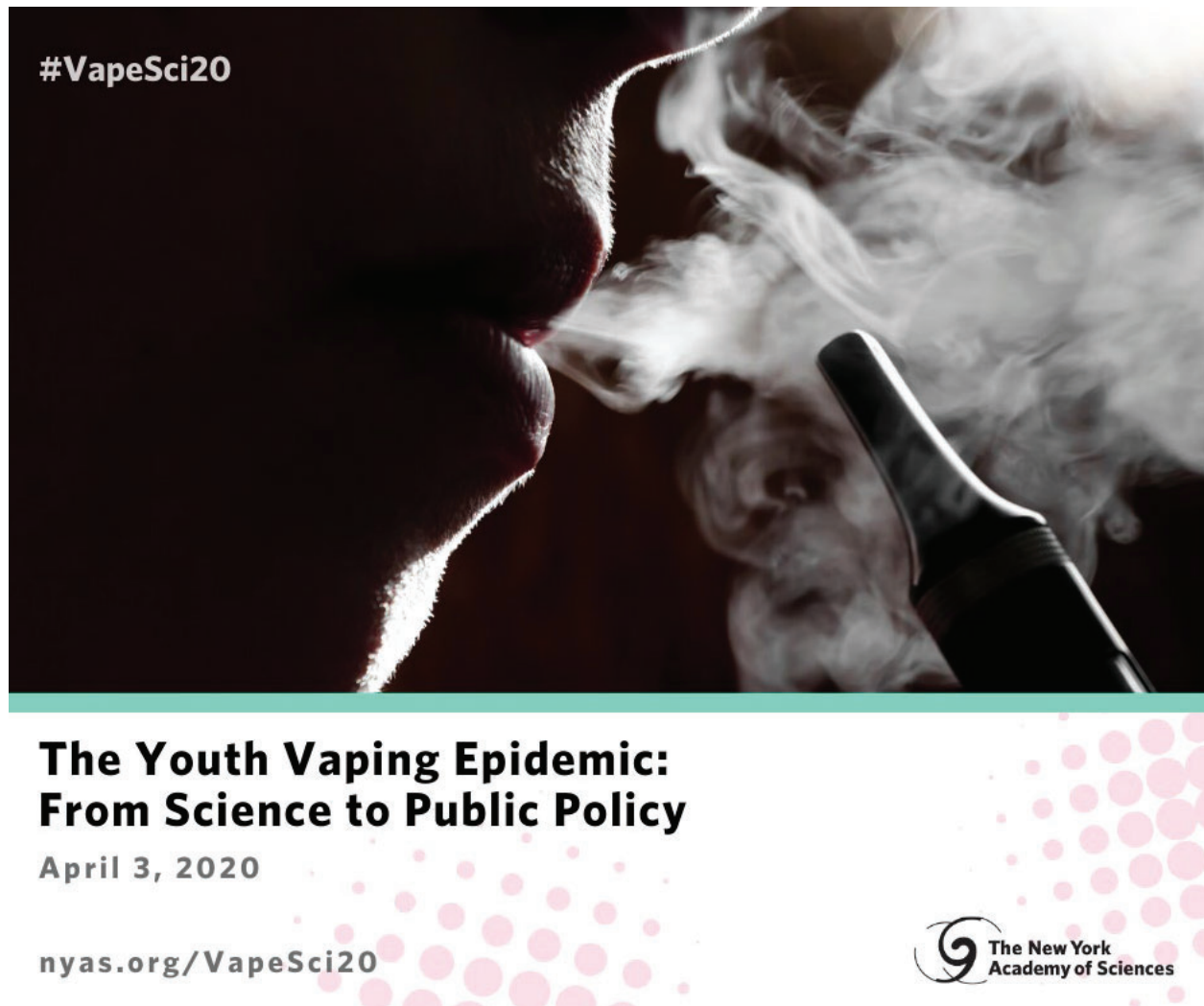
Suggested Facebook / LinkedIn post:

Join the New York Academy of Sciences on April 3rd for a symposium convening academic, public health and policy communities to discuss the emerging science behind the youth #vaping

epidemic and learn about evidence-based policy recommendations. Register here:

<https://bit.nyas.org/2OtnL3F>

Social card:



From: [Hillebrenner, Elizabeth J](#)
To: [Zucker, Howard A \(HEALTH\)](#); [Brazzell, Sarah E \(HEALTH\)](#)
Cc: [Shuren, Jeff](#)
Subject: RE: COVID-19 Outbreak
Date: Tuesday, February 25, 2020 3:41:35 PM
Attachments: [image001.png](#)

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Dr. Zucker,

Thank you for sharing your letter to Dr. Hahn. CDRH will work through his office on this matter.

Elizabeth

Elizabeth Hillebrenner

Associate Director for Scientific and Regulatory Programs
Center for Devices and Radiological Health
Office of the Center Director
U.S. Food and Drug Administration
Tel: 301-796-6346
elizabeth.hillebrenner@fda.hhs.gov



Excellent customer service is important to us. Please take a moment to provide feedback regarding the customer service you have received: <https://www.research.net/s/cdrhcustomerservice?ID=2000&S=E>.

From: Brazzell, Sarah E (HEALTH) <sarah.brazzell@health.ny.gov> **On Behalf Of** Zucker, Howard A (HEALTH)

Sent: Tuesday, February 25, 2020 2:18 PM

To: Hillebrenner, Elizabeth J <Elizabeth.Hillebrenner@fda.hhs.gov>

Subject: COVID-19 Outbreak

From: [Centers for Disease Control and Prevention](#)
To: [Dreslin, Sally R \(HEALTH\)](#)
Subject: Corrected Link: COCA Now: CDC's New "What's New" Weekly Email
Date: Monday, February 24, 2020 5:02:45 PM

ATTENTION: This email came from an external source. Do not open attachments or click on links from unknown senders or unexpected emails.



Sign-up to Receive CDC's New COVID-19 "What's New" Weekly Update

Dear COCA Partners and Subscribers,

We would like to share with you CDC's new COVID-19 "What's New" weekly E-Newsletter that is being launched this week.

We invite you to [sign up](#) to receive these weekly updates, delivered right to your

inbox, so you can stay current with this rapidly evolving situation.

Sincerely,

CDC's COCA Team

The Emergency Risk Communication Branch in the Division of Emergency Operations, Center for Preparedness and Response is responsible for the management of all COCA products.

For information about this update or other clinical issues, or to send your feedback, please contact us at coca@cdc.gov

[CDC Clinician Outreach and Communication Activity Facebook page](#)—connect with COCA on Facebook

[Clinician Outreach and Communication Activity](#)—resources for healthcare providers

[COCA RSS Feed](#)—subscribe to be notified of conference calls, updates, and CDC guidance for health providers

[Crisis & Emergency Risk Communication Training](#)—training program that draws from lessons learned during public health emergencies, and incorporates best practices from the fields of risk and crisis communication

[Health Alert Network](#)—CDC's primary method of sharing cleared information about urgent public health incidents with public information officers; federal, state, territorial, and local public health practitioners; clinicians; and public health laboratories



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Centers for Disease Control and Prevention

1600 Clifton Rd Atlanta, GA 30329 1-800-CDC-INFO (800-232-4636) TTY: 888-232-6348

[Questions or Problems](#) | [Unsubscribe](#)

From: [Centers for Disease Control and Prevention](#)
To: [Dreslin, Sally R \(HEALTH\)](#)
Subject: Corrected Link: CDC EPIC Extra: Sign-up to Receive CDC's New COVID-19 "What's New" Weekly Update
Date: Monday, February 24, 2020 4:59:06 PM

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February 24, 2020

EPIC Extra



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COVID-19 "What's New" Weekly Update

Sign-up to Receive CDC's New COVID-19 "What's New" Weekly Update

Dear CDC EPIC Partners and Subscribers,

We would like to share with you CDC's new COVID-19 "What's New" weekly E-Newsletter that is being launched this week.

We invite you to [sign up](#) to receive these weekly updates, delivered right to your inbox every Monday, so you can stay current with this rapidly evolving situation.

Sincerely,

CDC's EPIC Team

Contact Us

Email: EPIC@cdc.gov

Centers for Disease Control and Prevention
1600 Clifton Rd

Email icon



Atlanta, GA 30333

Questions?

[Contact CDC-INFO](#)

800-CDC-INFO (800-232-4636) TTY: 888-232-6348



Centers for Disease Control and Prevention

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From: [Centers for Disease Control and Prevention](#)
To: [Dreslin, Sally R \(HEALTH\)](#)
Subject: CDC EPIC Extra: Sign-up to Receive CDC's New COVID-19 "What's New" Weekly Update
Date: Monday, February 24, 2020 2:57:15 PM

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February 24, 2020

EPIC Extra



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Sincerely,

CDC's EPIC Team

Contact Us

Email: EPIC@cdc.gov

Centers for Disease Control and Prevention
1600 Clifton Rd

Email icon



Atlanta, GA 30333

Questions?

[Contact CDC-INFO](#)

800-CDC-INFO (800-232-4636) TTY: 888-232-6348



Centers for Disease Control and Prevention

1600 Clifton Rd Atlanta GA 30329 1-800-CDC-INFO (800-232-4636) TTY: 888-232-6348

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From: [Centers for Disease Control and Prevention](#)
To: [Dreslin, Sally R \(HEALTH\)](#)
Subject: CDC COCA Now: Sign-up to Receive CDC's New COVID-19 "What's New" Weekly Update
Date: Monday, February 24, 2020 2:21:35 PM

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Sign-up to Receive CDC's New COVID-19 "What's New" Weekly Update

Dear COCA Partners and Subscribers,

We would like to share with you CDC's new COVID-19 "What's New" weekly E-Newsletter that is being launched this week.

We invite you to [sign up](#) to receive these weekly updates, delivered right to your

inbox, so you can stay current with this rapidly evolving situation.

Sincerely,

CDC's COCA Team

The Emergency Risk Communication Branch in the Division of Emergency Operations, Center for Preparedness and Response is responsible for the management of all COCA products.

For information about this update or other clinical issues, or to send your feedback, please contact us at coca@cdc.gov

[CDC Clinician Outreach and Communication Activity Facebook page](#)—connect with COCA on Facebook

[Clinician Outreach and Communication Activity](#)—resources for healthcare providers

[COCA RSS Feed](#)—subscribe to be notified of conference calls, updates, and CDC guidance for health providers

[Crisis & Emergency Risk Communication Training](#)—training program that draws from lessons learned during public health emergencies, and incorporates best practices from the fields of risk and crisis communication

[Health Alert Network](#)—CDC's primary method of sharing cleared information about urgent public health incidents with public information officers; federal, state, territorial, and local public health practitioners; clinicians; and public health laboratories



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From: Karl Ensign <kensign@astho.org>

Sent: Monday, February 24, 2020 1:06 PM

To: Esther Muna <esther.muna@dph.gov.mp>; Livinson Taulung (LTaulung2@fsmhealth.fm) <LTaulung2@fsmhealth.fm>; Laurent Duenas, MPH, BSN, RN <Laurent.Duenas@dphss.guam.gov>; Emais Roberts <emais.roberts@palauhealth.org>; Catherine de la Cruz Duran <catherine.delacruz@salud.pr.gov>; Bruce Bilimon [REDACTED]; RN BSN MBA/HCM Justa (Tita) Encarnacion [REDACTED]; Nate Smith <nathaniel.smith@arkansas.gov>; Angell, Sonia Y@CDPH <Sonia.Angell@cdph.ca.gov>; scott.rivkees@flhealth.gov <scott.rivkees@flhealth.gov>; bruce.s.anderson@doh.hawaii.gov <bruce.s.anderson@doh.hawaii.gov>; Howard Zucker <howard.zucker@health.ny.gov>; John Wiesman <jmwiesman@doh.wa.gov>; Motusa Nua <tuinua@doh.as>

Cc: Reva Ferguson <Reva.Ferguson@arkansas.gov>; Rachelle Ashe <rachelle.ashe@arkansas.gov>; Peggy Ullom <peggy.ullom@cdph.ca.gov>; linda.fullem@flhealth.gov <linda.fullem@flhealth.gov>; Tangonan, Sharon S. <Sharon.Tanganon@doh.hawaii.gov>; Jacqueline Silvia <jacki.silvia@health.ny.gov>; Terry Bergener <terry.bergener@doh.wa.gov>; Eti Uiagalelei <euigalelei@doh.as>; Janet Guerrero <janet.guerrero@dph.gov.mp>; Fancy Soloman <fsolomon@fsmhealth.fm>; Suzanne Kaneshiro <suzanne.kaneshiro@dphss.guam.gov>; Lalie Ikluk <lalie.ikluk@palauhealth.org>; Marline Loeak [REDACTED]; Louise Baa <louise.baa@doh.vi.gov>; Aniah John <Aniah.John@doh.vi.gov>; Carolyn Mullen <cmullen@astho.org>; Michael Fraser <mfraser@astho.org>; Joe Davis <jdavis@astho.org>; Taveras, Sam (CDC/OSTLTS/DPHCD) <syt2@cdc.gov>; Jose T. Montero, MD, MPH <znn3@cdc.gov>; Subroto Banerji <subroto.banerji@dph.gov.mp>; lauri.ogumoro@dph.gov.mp <lauri.ogumoro@dph.gov.mp>; Danny Staley <dstaley@astho.org>; Carolyn McCoy <cmccoy@astho.org>; Cendra Clarke <cclarke@astho.org>; Christi Mackie <cmackie@astho.org>; Mark Mioduski <mmioduski@cgagroup.com>; Emi Chutaro (emic@pihoa.org) <emic@pihoa.org>; Gallo, Bill (CDC/OSTLTS/DPHCD) <wkg1@cdc.gov>; Ottley, Basil C <basil_ottley@ios.doi.gov>

Subject: Canceled: Materials & Time Change for Subcommittee on IA During ASTHO WA Week -- CANCELLED

When: Tuesday, February 25, 2020 5:00 PM-6:30 PM.

Where: Madison Hotel – Adams B, 1177 15th Street, NW, Washington, DC 20005

Dear Subcommittee on Insular Affairs Members & Meeting Participants –

Well, change is a constant!! Given that we have a last minute request from the White House for our members to brief officials on COVID-19 while they are in town, the meeting of the Subcommittee on Insular Affairs held during Washington Week will be cancelled this year. However, in the absence of the full committee meeting, Cendra and I would still appreciate having a working session with our partners and staff not traveling to the White House tomorrow to further our priorities and action steps for the coming year. It is critical that we keep this work moving. I have emailed these individuals separately.

Apologies for multiple emails.

Thanks,
Karl

From: Karl Ensign

Sent: Sunday, February 23, 2020 3:35 PM

To: esther.muna@dph.gov.mp; Livinson Taulung (LTaulung2@fsmhealth.fm)
<LTaulung2@fsmhealth.fm>; Laurent Duenas, MPH, BSN, RN <laurent.duenas@dphss.guam.gov>;
Emais Roberts MD (emaais.roberts@palauhealth.org) <emaais.roberts@palauhealth.org>; Catherine
de la Cruz Duran <catherine.delacruz@salud.pr.gov>; Bruce Bilimon
[REDACTED]; RN BSN MBA/HCM Justa (Tita) Encarnacion
[REDACTED] Nate Smith, MD
<Nathaniel.Smith@arkansas.gov>; Angell, Sonia Y@CDPH <Sonia.Angell@cdph.ca.gov>;
scott.rivkees@flhealth.gov; bruce.s.anderson@doh.hawaii.gov; howard.zucker@health.ny.gov; John
Wiesman <jmwiesman@doh.wa.gov>; Motusa Nua <tuinua@doh.as>
Cc: Subroto Banerji <subroto.banerji@dph.gov.mp>; lauri.ogumoro@dph.gov.mp; Reva Ferguson
<Reva.Ferguson@arkansas.gov>; 'Rachelle Ashe' <rachelle.ashe@arkansas.gov>; Peggy Ullom
<Peggy.Ullom@cdph.ca.gov>; linda.fuller@flhealth.gov; Tangonan, Sharon S.
<Sharon.Tangonan@doh.hawaii.gov>; Jacqueline Silvia <jacki.silvia@health.ny.gov>; Terry Bergener
<terry.bergener@doh.wa.gov>; Eti Uiagalelei <euigalelei@doh.as>; Janet Guerrero
<janet.guerrero@dph.gov.mp>; Fancy Solomon <fsolomon@fsmhealth.fm>; Suzanne Kaneshiro
<suzanne.kaneshiro@dphss.guam.gov>; Lalie Ikluk <lalie.ikluk@palauhealth.org>; Marline Loeak
[REDACTED]; Louise Baa <louise.baa@doh.vi.gov>; Aniah John
<Aniah.John@doh.vi.gov>; Danny Staley <dstaley@astho.org>; Carolyn McCoy
<cmccoy@astho.org>; Carolyn Mullen <cmullen@astho.org>; Michael Fraser <mfraser@astho.org>;
Cendra Clarke <cclarke@astho.org>; Christi Mackie <cmackie@astho.org>; Mark Mioduski
<mmioduski@cgagroup.com>; Joe Davis <jdavis@astho.org>; Emi Chutaro (emic@pihoa.org)
<emic@pihoa.org>; Taveras, Sam (CDC/OSTLTS/DPHCD) <syt2@cdc.gov>; Gallo, Bill
(CDC/OSTLTS/DPHCD) <wkg1@cdc.gov>; Jose T. Montero, MD, MPH (znn3@cdc.gov)
<znn3@cdc.gov>; Ottley, Basil C <basil_ottley@ios.doi.gov>

Subject: Materials & Time Change for Subcommittee on IA During ASTHO WA Week

Dear Subcommittee on Insular Affairs Members & Meeting Participants,

On behalf of Subcommittee Chair Esther Muna, CNMI and ASTHO CEO Mike Fraser, we welcome you to Washington Week and thank you for your active engagement and participation! Please note our meeting has been changed to the following date and time:

Tuesday, February 25th, 2020

4:00 – 5:30 pm ET

Madison Hotel – Adams B

1177 15th Street, NW

Washington, DC 20005

A calendar invite will follow.

Attached and below please find materials for our meeting. During our time together, we will re-visit the priorities established during last year's meeting, hear about progress made on these, and define action steps and priorities for the coming year. Also, please note that during or after the Tuesday dinner, those of us visiting on the Hill Wednesday and engaging in meetings with the Administration on Thursday will huddle to hone talking points.

https://naturalresources.house.gov/imo/media/doc/Insular%20Fact%20Sheet_ks.pdf

<https://scholarlycommons.pacific.edu/pjh/vol2/iss1/1/>

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See you soon!

Karl

Karl Ensign, Chief

Territorial Support

Gender Pronouns: He/Him/His

Association of State and Territorial Health Officials

National Headquarters: 2231 Crystal Drive, Suite 450,
Arlington, VA 22202

Regional Office: 600 Peachtree Street NE, Suite 1000,
Atlanta, GA 30308

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From: [Karl Ensign](#)
To: [Esther Muna](#); [Livinson Taulung \(LTaulung2@fsmhealth.fm\)](#); [Laurent Duenas, MPH, BSN, RN](#); [Emais Roberts](#); [Catherine de la Cruz Duran](#); [Bruce Bilimon](#); [RN BSN MBA/HCM Justa \(Tita\) Encarnacion](#); [Nate Smith](#); [Angell, Sonia Y@CDPH](#); [scott.rivkees@flhealth.gov](#); [bruce.s.anderson@doh.hawaii.gov](#); [Zucker, Howard A \(HEALTH\)](#); [John Wiesman](#); [Motusa Nua](#)
Cc: [Subroto Banerji](#); [lauri.ogumoro@dph.gov.mp](#); [Reva Ferguson](#); [Rachelle Ashe](#); [Peggy Ullom](#); [linda.fuller@flhealth.gov](#); [Tangonan, Sharon S.](#); [Silvia, Jacqueline S \(HEALTH\)](#); [Terry Bergener](#); [Eti Uiagalelei](#); [Janet Guerrero](#); [Fancy Soloman](#); [Suzanne Kaneshiro](#); [Lalie Ikluk](#); [Marline Loeak](#); [Louise Baa](#); [Aniah John](#); [Danny Staley](#); [Carolyn McCoy](#); [Carolyn Mullen](#); [Michael Fraser](#); [Cendra Clarke](#); [Christi Mackie](#); [Mark Mioduski](#); [Joe Davis](#); [Emi Chutaro \(emic@pihoa.org\)](#); [Taveras, Sam \(CDC/OSTLTS/DPHCD\)](#); [Gallo, Bill \(CDC/OSTLTS/DPHCD\)](#); [Jose T. Montero, MD, MPH](#); [Ottley, Basil C](#)
Subject: RE: Materials & Time Change for Subcommittee on IA During ASTHO WA Week -- CANCELLED
Date: Monday, February 24, 2020 11:59:49 AM
Attachments: [image001.png](#)

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Well, change is a constant!! Given that we have a last minute request from the White House for our members to brief officials on COVID-19 while they are in town, the meeting of the Subcommittee on Insular Affairs held during Washington Week will be cancelled this year. However, in the absence of the full committee meeting, Cendra and I would still appreciate having a working session with our partners and staff not traveling to the White House tomorrow to further our priorities and action steps for the coming year. It is critical that we keep this work moving. I have emailed these individuals separately.

Apologies for multiple emails.

Thanks,
Karl

From: Karl Ensign
Sent: Sunday, February 23, 2020 3:35 PM
To: [esther.muna@dph.gov.mp](#); [Livinson Taulung \(LTaulung2@fsmhealth.fm\)](#) <[LTaulung2@fsmhealth.fm](#)>; [Laurent Duenas, MPH, BSN, RN](#) <[laurent.duenas@dphss.guam.gov](#)>; [Emais Roberts MD \(email.roberts@palauhealth.org\)](#) <[email.roberts@palauhealth.org](#)>; [Catherine de la Cruz Duran](#) <[catherine.delacruz@salud.pr.gov](#)>; [Bruce Bilimon](#) <[REDACTED]>; [RN BSN MBA/HCM Justa \(Tita\) Encarnacion](#) <[REDACTED]>; [Nate Smith, MD](#) <[Nathaniel.Smith@arkansas.gov](#)>; [Angell, Sonia Y@CDPH](#) <[Sonia.Angell@cdph.ca.gov](#)>; [scott.rivkees@flhealth.gov](#); [bruce.s.anderson@doh.hawaii.gov](#); [howard.zucker@health.ny.gov](#); [John Wiesman](#) <[jmwiesman@doh.wa.gov](#)>; [Motusa Nua](#) <[tuinua@doh.as](#)>
Cc: [Subroto Banerji](#) <[subroto.banerji@dph.gov.mp](#)>; [lauri.ogumoro@dph.gov.mp](#); [Reva Ferguson](#) <[Reva.Ferguson@arkansas.gov](#)>; [Rachelle Ashe](#) <[rachelle.ashe@arkansas.gov](#)>; [Peggy Ullom](#) <[Peggy.Ullom@cdph.ca.gov](#)>; [linda.fuller@flhealth.gov](#); [Tangonan, Sharon S.](#) <[Sharon.Tangonan@doh.hawaii.gov](#)>; [Jacqueline Silvia](#) <[jacki.silvia@health.ny.gov](#)>; [Terry Bergener](#) <[terry.bergener@doh.wa.gov](#)>; [Eti Uiagalelei](#) <[euiagalelei@doh.as](#)>; [Janet Guerrero](#) <[janet.guerrero@dph.gov.mp](#)>; [Fancy Soloman](#) <[fsolomon@fsmhealth.fm](#)>; [Suzanne Kaneshiro](#)

<suzanne.kaneshiro@dphss.guam.gov>; Lalie Ikluuk <lalie.ikluuk@palauhealth.org>; Marline Loeak [REDACTED]; Louise Baa <louise.baa@doh.vi.gov>; Aniah John <Aniah.John@doh.vi.gov>; Danny Staley <dstaley@astho.org>; Carolyn McCoy <cmccoy@astho.org>; Carolyn Mullen <cmullen@astho.org>; Michael Fraser <mfraser@astho.org>; Cendra Clarke <cclarke@astho.org>; Christi Mackie <cmackie@astho.org>; Mark Mioduski <mmioduski@cgagroup.com>; Joe Davis <jdavis@astho.org>; Emi Chutaru (emic@pihoa.org) <emic@pihoa.org>; Taveras, Sam (CDC/OSTLTS/DPHCD) <syt2@cdc.gov>; Gallo, Bill (CDC/OSTLTS/DPHCD) <wkg1@cdc.gov>; Jose T. Montero, MD, MPH (znn3@cdc.gov) <znn3@cdc.gov>; Ottley, Basil C <basil_ottley@ios.doi.gov>
Subject: Materials & Time Change for Subcommittee on IA During ASTHO WA Week

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<https://scholarlycommons.pacific.edu/pjh/vol2/iss1/1/>

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Karl

Karl Ensign, Chief

Territorial Support
Gender Pronouns: He/Him/His

Association of State and Territorial Health Officials
National Headquarters: 2231 Crystal Drive, Suite 450,
Arlington, VA 22202
Regional Office: 600 Peachtree Street NE, Suite 1000,
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[REDACTED]

From: CDC IMS State Coordination Task Force (SCTF) Operations <eocscfops@cdc.gov>
Sent: Thursday, January 16, 2020 11:24 PM
To: CDC IMS State Coordination Task Force (SCTF) Operations
Cc: Zucker, Howard A (HEALTH)
Subject: All State Update Call - 2019 nCoV
When: Occurs every Monday effective 1/27/2020 until 3/2/2020 from 2:00 PM to 3:00 PM Eastern Standard Time.
Where: Bridgeline: 1(800)857-6697 Participant Passcode: [REDACTED]

ATTENTION: This email came from an external source. Do not open attachments or click on links from unknown senders or unexpected emails.

CDC's 2019 Novel Coronavirus (2019-nCoV) response team will continue a series of national calls from 2 p.m. to 3 p.m. EST on Monday, January 27, to provide state and local partners with the latest information on the novel coronavirus outbreak and U.S. preparedness efforts.

Invited participants include state, local, and territorial preparedness directors, state epidemiologists, state health officials, public health laboratory directors, and nongovernmental partners. Participant information can be found below.

Participant Information

Bridgeline: 1(800)-857-6697

Participant Passcode: [REDACTED]

For your convenience, call series dates are provided below.

- * Monday, February 3
- * Monday, February 10
- * Monday, February 24
- * Monday, March 2

CDC State Coordination Task Force (SCTF) - Operations

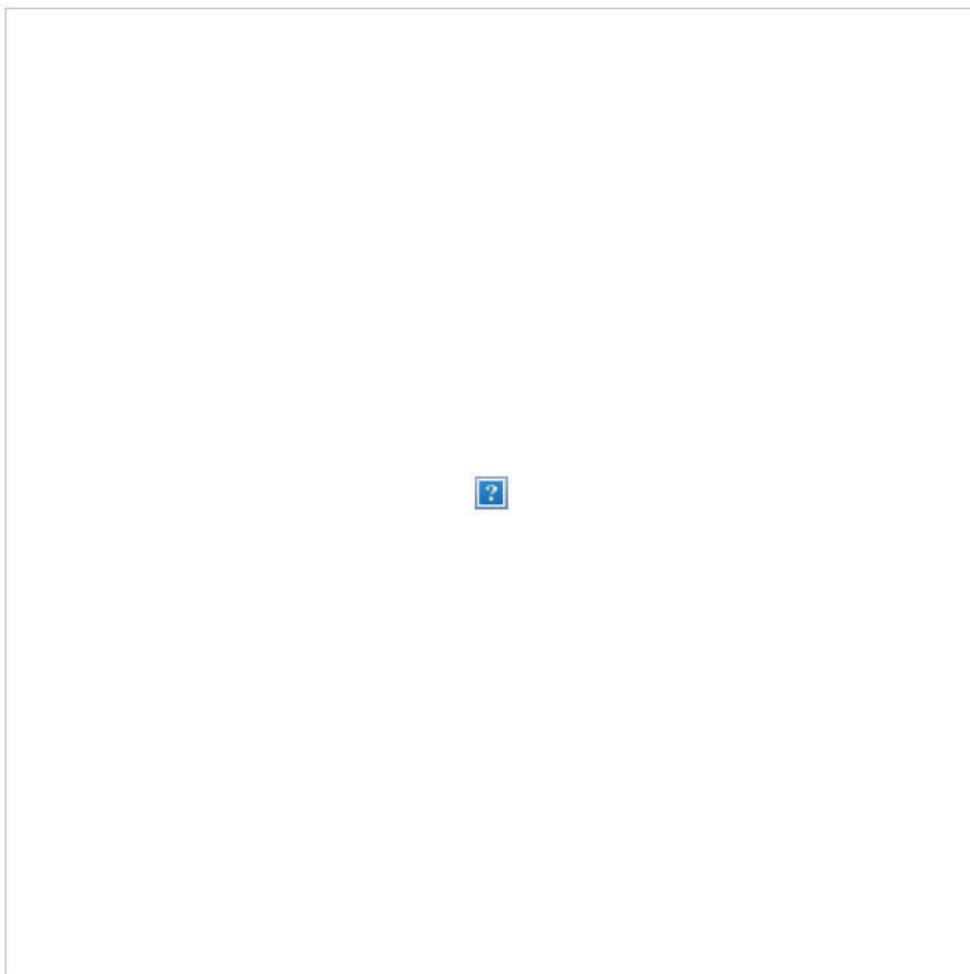
eocscfops@cdc.gov <mailto:eocscfops@cdc.gov>

<https://www.cdc.gov/coronavirus/novel-coronavirus-2019.html> <https://www.cdc.gov/coronavirus/novel-coronavirus-2019.html>

From: [U.S. Food and Drug Administration](#)
To: [Zucker, Howard A \(HEALTH\)](#)
Subject: FDA Warns Against Coronavirus-themed Phishing Emails
Date: Friday, February 21, 2020 5:30:28 PM

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February 21, 2020

Dear Colleagues,

Please be aware that malicious cybercriminals are attempting to leverage interest and activity in the coronavirus to launch coronavirus-themed phishing emails.

These phishing emails contain links and downloads for malware that can allow them to take over healthcare information technology (IT) systems and steal information. Victims who interact with malicious links or attachments may expose their systems, networks, and valuable information. At least one campaign is pretending to send emails from the Centers for Disease Control and Prevention, and target Americans and other English-speaking victims with attached notices regarding infection-prevention measures for the disease. We have also observed that some phishing attempts claim new information and updates regarding new cases of infection in recipients' areas.

As always, it is vital for government computer users to verify the validity of links before clicking on them and immediately report any suspected phishing examples to your IT administrators.

Below are additional links for the novel coronavirus (COVID-19) information.

COVID 19 Web Resources:

US FDA COVID-19:

<https://www.fda.gov/emergency-preparedness-and-response/mcm-issues/novel-coronavirus-covid-19>

COVID-19 Outbreak Tracker. [Johns Hopkins](#)

<https://gisanddata.maps.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6>

COVID-19 Outbreak Tracker. Kaiser Family Foundation <https://www.kff.org/global-health-policy/fact-sheet/coronavirus-tracker/>

WHO <https://www.who.int/emergencies/diseases/novel-coronavirus-2019>

EU European Centre for Disease Prevention and Control. COVID-19 site

<https://www.ecdc.europa.eu/en/novel-coronavirus-china>

UK Government COVID-19 Publications <https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control>

US DHHS PHE.GOV <https://www.phe.gov/Preparedness/COVID19/Pages/default.aspx>

US DHHS CDC <https://www.cdc.gov/coronavirus/2019-ncov/>

US DHHS CDC NIOSH https://www.cdc.gov/niosh/emres/2019_ncov.html

US Dpt of Labor OSHA <https://www.osha.gov/SLTC/covid-19/>

USA GOV International Traveler Issues for Americans <https://www.usa.gov/americans-abroad#item-214568>

WHO on-line course <https://openwho.org/courses/introduction-to-ncov>

[Network for Public Health Law. Coronavirus Primer. Authorities, etc...](#)
<https://www.networkforphl.org/resources/emergency-legal-preparedness-wuhan-coronavirus/>

This message is being broadcast by the Division of Communications in FDA's Office of Regulatory Affairs (ORA).

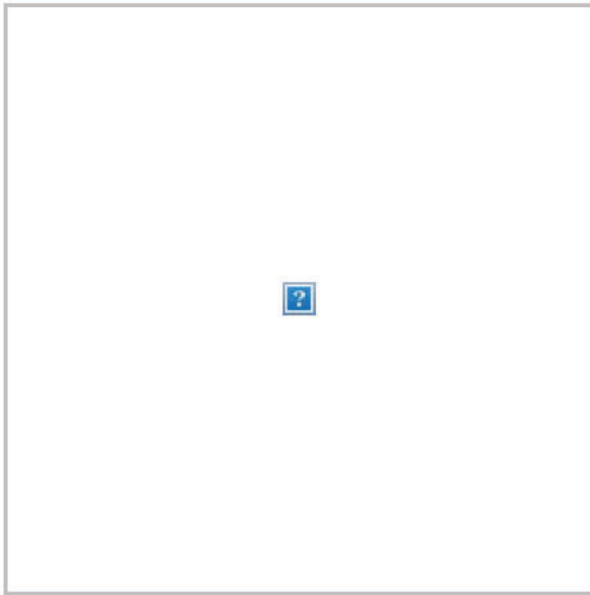
Thank you,

FDA/ORA

Office of Communications and Project Management

Division of Communications

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From: CDC IMS State Coordination Task Force (SCTF) TF Coordinations TM
To: Stevens, Kelly (CDC adph.state.al.us); McLaughlin, Joseph (CDC alaska.gov); eugene.livar@azdhs.gov; Smith, Nathaniel (CDC arkansas.gov); catherine.waters@arkansas.gov; sonia.angell@cdph.ca.gov; Black, Stephanie SB (CDC cityofchicago.org); Herlihy, Rachel (CDC state.co.us); Coleman, Renee (CDC ct.gov); Heather.Aaron@ct.gov; doh.epi@dc.gov; karyl.rattay@delaware.gov; Paula.Eggers@delaware.gov; Roberson, Shamari (CDC flhealth.gov); Drenzek, Cherie (CDC dph.ga.gov); Park, Sarah Y., MD; Elke.Shaw-Tulloch@dhw.idaho.gov; Katherine.Turner@dhw.idaho.gov; molly.lamb@illinois.gov; kbox@isdh.in.gov; Pontones, Pamela (CDC isdh.in.gov); Pedati, Caitlin; farah.ahmed@ks.gov; White, Connie (CDC ky.gov); Nirav.shah@maine.gov; Bennett, Siiri (CDC maine.gov); fran.phillips@maryland.gov; catherine.brown@state.ma.us; lyoncallos@michigan.gov; isarofalpiy@fsmhealth.fm; jan.malcolm@state.mn.us; Lynfield, Ruth (CDC state.mn.us); Thomas.Dobbs@msdh.ms.gov; Randall.Williams@health.mo.gov; Anderson, Stacey (CDC mt.gov); eric.sergeant@nebraska.gov; mpeekbullock@health.nv.gov; jazzam@health.nv.gov; benjamin.chan@dhhs.nh.gov; christopher.neuwirth@doh.nj.gov; chelsea.mcmullen@state.nm.us; Demetre Daskalakis; Zucker, Howard A (HEALTH); Blog, Debra S (HEALTH); Moore, Zackary (CDC dhhs.nc.gov); myllyntufte@nd.gov; Muña, Esther (CDC dph.gov.mp); Amy.Acton@odh.ohio.gov; GaryC@health.ok.gov; MELISSA.E.POWELL@dhsosha.state.or.us; [REDACTED]; Alexander-Scott, Nicole (CDC health.ri.gov); blairjd@dhsc.sc.gov; Lindquist, Scott SL (CDC doh.wa.gov); josh.clayton@state.sd.us; Dunn, John (CDC tn.gov); Ellis, Esther (CDC doh.vi.gov); Dunn, Angela (CDC utah.gov); Kelso, Patsy (CDC vermont.gov); lilian.peake@vdh.virginia.gov; cathy.c.slemp@wv.gov; jeanne.ayers@dhs.wisconsin.gov; Harrist, Alexia (CDC wyo.gov); jennifer.shuford@dshs.texas.gov; joy.zimmermanbodi@dshs.texas.gov; Linda.denorvey@dphss.quam.gov; alexander.billieux@la.gov; ralevine@pa.gov; bbilimon@hotmail.com; emais.roberts@palauhealth.org; Nua, Motusa Tuileama (CDC doh.as); Arwady, Allison AA (CDC cityofchicago.org); BFerrer@ph.lacounty.gov
Cc: McLaughlin, Joseph (CDC alaska.gov); Davidson, Sherri (CDC adph.state.al.us); a.tufa@doh.as; Louie, Shirley (CDC arkansas.gov); Komatsu, Kenneth (CDC azdhs.gov); Watt, James (CDC cdph.ca.gov); Herlihy, Rachel (CDC state.co.us); Tolliver, Rickey (CDC state.co.us); Cartter, Matthew (CDC ct.gov); Davies-Cole, John (CDC dc.gov); Tabatha.Offutt-Powell@state.de.us; Skilling, Vita A. (CDC fsmhealth.fm); Blackmore, Carina (CDC flhealth.gov); Drenzek, Cherie (CDC dph.ga.gov); Ann.Pobutsky@dphss.quam.gov; Park, Sarah Y., MD; Pedati, Caitlin; Hahn, Christine G. <ID> (CDC dhw.idaho.gov); Layden, Jennifer (CDC illinois.gov); Pontones, Pamela (CDC isdh.in.gov); farah.ahmed@ks.gov; Thoroughman, Douglas (CDC ky.gov); Ratard, Raoult (CDC la.gov); catherine.brown@state.ma.us; Blythe, David (CDC maryland.gov); Bennett, Siiri (CDC maine.gov); lyoncallos@michigan.gov; Lynfield, Ruth (CDC state.mn.us); george.turabelidze@health.mo.gov; paul.byers@msdh.ms.gov; Williamson, Laura (CDC mt.gov); Moore, Zackary (CDC dhhs.nc.gov); Miller, Tracy (CDC nd.gov); Safraneck, Thomas <NE> (CDC nebraska.gov); benjamin.chan@dhhs.nh.gov; Tan, Christina (CDC doh.state.nj.us); Landen, Michael (CDC state.nm.us); paul.white@dph.gov.mp; mpeekbullock@health.nv.gov; Blog, Debra S (HEALTH); deFijter, Sietske (CDC odh.ohio.gov); Burnsed, Laurence (CDC health.ok.gov); dean.e.sidelinger@dhsosha.state.or.us; shawatkings@pa.gov; carmen.deseda@salud.pr.gov; Bandy, Utpala (CDC health.ri.gov); Bell, Linda (CDC dhsc.sc.gov); Clayton, Joshua (CDC state.sd.us); Dunn, John (CDC tn.gov); Gaul, Linda (CDC dshs.state.tx.us); Ellis, Esther (CDC doh.vi.gov); Dunn, Angela (CDC utah.gov); lilian.peake@vdh.virginia.gov; Kelso, Patsy (CDC vermont.gov); Cragin, Lori (CDC vermont.gov); Lindquist, Scott SL (CDC doh.wa.gov); Wasserman, Cathy (CDC doh.wa.gov); jonathan.meiman@dhs.wisconsin.gov; Ryan.Westergaard@dhs.wisconsin.gov; Del Rosario, Maria (CDC wv.gov); Harrist, Alexia (CDC wyo.gov)
Subject: Urgent Time Sensitive: Requesting 24/7 Phone Contact Information for COVID-19 Returning Travelers
Date: Friday, February 14, 2020 11:56:55 AM

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Good Morning,

We need your help, please.

CDC is finalizing the COVID-19 Check and Report (CARE) booklets that will be given to passengers entering the United States who have traveled from China and will be self-monitoring.

We will be providing China travelers with a phone number to contact their state health department if they have questions or develop symptoms.

Please provide the **telephone number** travelers should contact for your state that is staffed 24/7 by COB today.

Thank you
State Coordination Task Force
Regional Desk

State Coordination Task Force (SCTF)
Regional Coordination Team - eocsctftfcoord@cdc.gov
Center for Preparedness and Response (CPR)
404-232-0480

From: [LeBlanc, Tanya \(CDC/DDPHSIS/CPR/DSLRL\)](#)
To: [Patel, Manisha M. \(CDC/DDID/NCIRD/DVD\)](#); [Dylsia Cruz](#); [Iskander, John \(CDC/DDPHSS/OS/OD\)](#); [obarbot@health.nyc.gov](#); [Zucker, Jane R. \(CDC health.nyc.gov\)](#); [Zucker, Howard A \(HEALTH\)](#); [Cohn, Amanda \(CDC/DDID/NCIRD/OD\)](#); [Smith, Tiffany \(CDC/DDID/NCIRD/OD\) \(CTR\)](#); [Laird, Susan \(CDC/OD/OADC\)](#); [Eriksen, Paula \(CDC/OD/OADC\) \(CTR\)](#); [Patrick, Holly \(CDC/DDID/NCIRD/DVD\)](#); [Schneider, Allison \(CDC/DDID/NCIRD/OD\)](#); [Adriana Joseph](#); [Brazzell, Sarah E \(HEALTH\)](#); [Silvia, Jacqueline S \(HEALTH\)](#); [Kerri McManhan](#); [Marisa Langdon-Embry](#); [Blog, Debra S \(HEALTH\)](#); [Sutton, Barbara \(HEALTH\)](#)
Cc: [St. Pierre, Jeanette \(CDC/DDID/NCIRD/DVD\)](#)
Subject: RE: February 2020 Public Health Grand Rounds Slides Final
Date: Thursday, February 13, 2020 2:29:10 PM
Attachments: [image001.png](#)
[PHGR-February-18-2020-Measles-final.pdf](#)
[Map-Roybal.pdf-508.pdf](#)

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Dear All, Thank you so much for your expertise and collaboration in producing what we believe will be an outstanding contribution to the Centers for Disease Control and Prevention's Public Health Grand Rounds 2020 series. Here are the slides that will be presented next week during your session:

“Measles – Maintaining Disease Elimination and Enhancing Vaccine Confidence”

Tuesday, February 18, 2020

1:00 p.m. – 2:00 p.m. (ET)

Global Communications Center (Building 19)

Alexander D. Langmuir Auditorium

Speaker Report Place/Time: On February 18, 2020, all speakers please report to CDC's Roybal Campus, Building 19 Alexander D. Langmuir Auditorium no later than 12:15pm.

The street address is: 1600 Clifton Road NE, Atlanta, GA 30329-4018

The front entrance to CDC's Roybal Campus is under construction. Those traveling from New York, please give yourselves time to enter the campus, and undergo the required security check.

The PHGR staff looks forward to greeting you. A campus map is attached for your convenience.

Please contact me at any time if you have questions or concerns.

Best regards and safe travels!!

Tanya Telfair LeBlanc, PhD, MS
Senior Health Scientist on Detail to the Office of Science
Centers for Disease Control and Prevention
(404) 639-2976- Office
[REDACTED] – Cell

Tleblanc@cdc.gov

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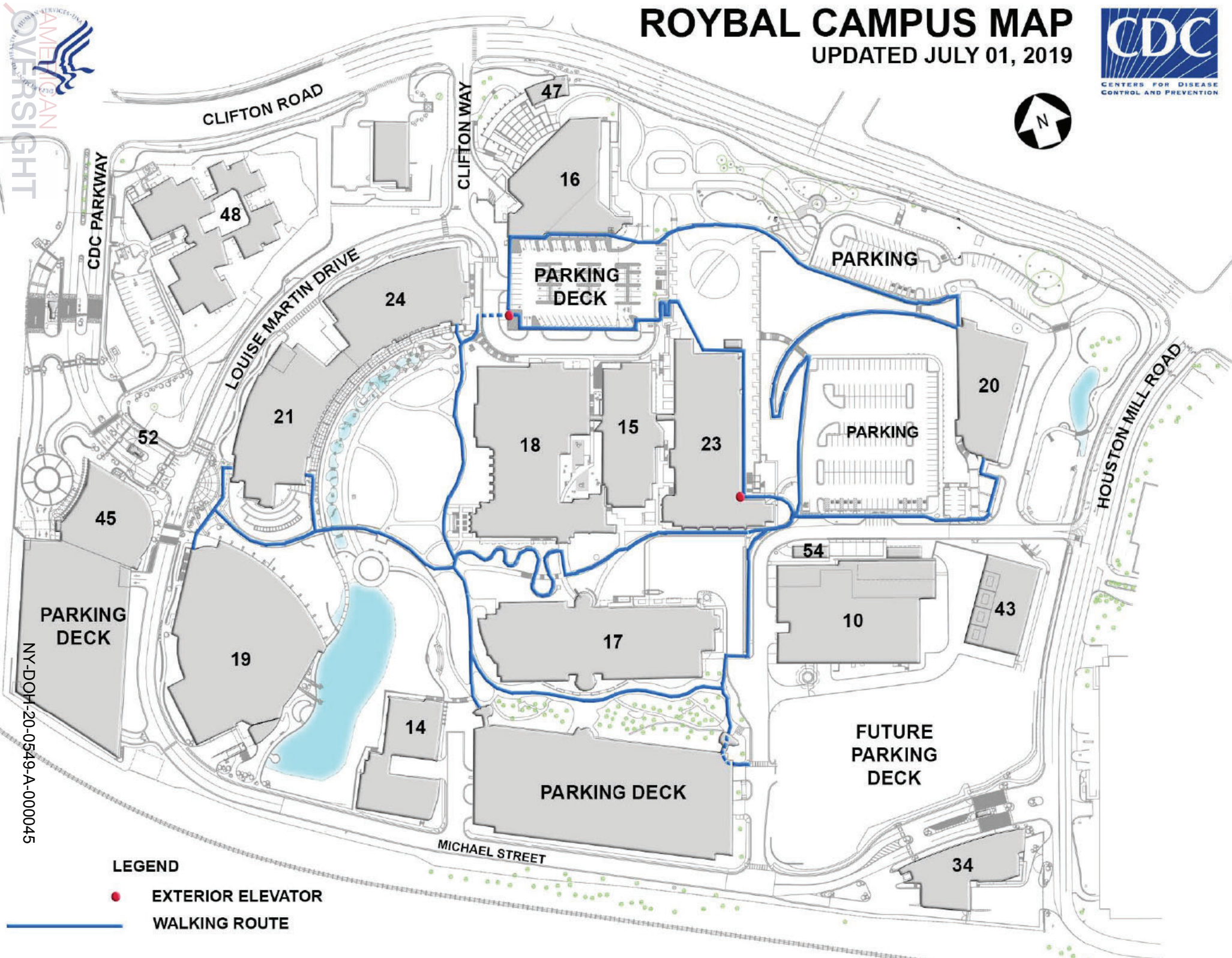
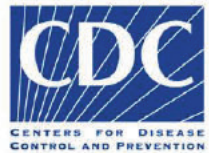
Room 5117

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ROYBAL CAMPUS MAP

UPDATED JULY 01, 2019

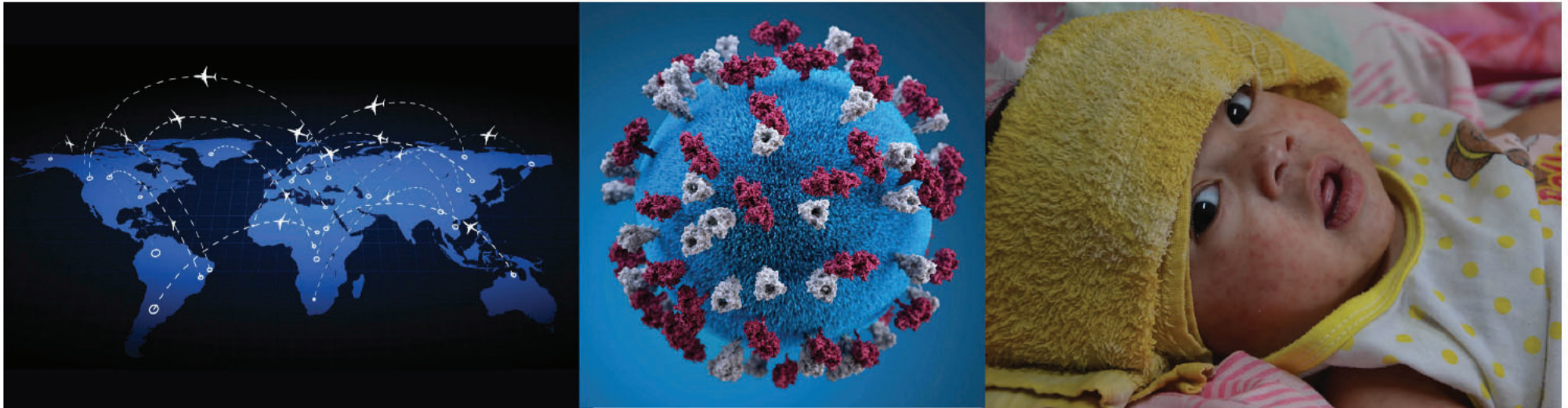


LEGEND

- EXTERIOR ELEVATOR
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CDC PUBLIC HEALTH GRAND ROUNDS

Measles – Maintaining Disease Elimination and Enhancing Vaccine Confidence



Tuesday, February 18, 2020
1:00 p.m. – 2:00 p.m. (ET)

Continuing Education Information

Continuing education: www.cdc.gov/getce

- After creating a TCEO account, click the “Search Courses” tab on the left and use “Public Health Grand Rounds” as a keyword search.
- All PHGR sessions eligible for CE should display, select the link for today’s session and then Continue button. [Course Access Code is PHGR10](#).
- CE expires **March 23, 2020** for live and **February 20, 2022** for Web On Demand courses.
- Issues regarding CE and CDC Grand Rounds, email: tceo@cdc.gov

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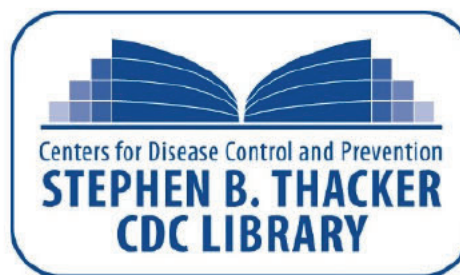
Additional Resources

Beyond The Data

**“Take home” messages in a
short podcast at:
cdc.gov/grand-rounds**



science**clips**
CDC



**Scientific publications about
this topic at:
cdc.gov/library/sciclips**

Email grandrounds@cdc.gov with any questions or for help locating the additional resources

Today's Speakers and Contributors



**Manisha Patel, MD, MS
(CDR USPHS)**

**Medical Officer, National Center
for Immunization and
Respiratory Diseases, CDC**



**Howard Zucker, MD, JD
New York State Health Commissioner**



**Oxiris Barbot, MD
Commissioner of Health, NYC
Department of Health and
Mental Hygiene**

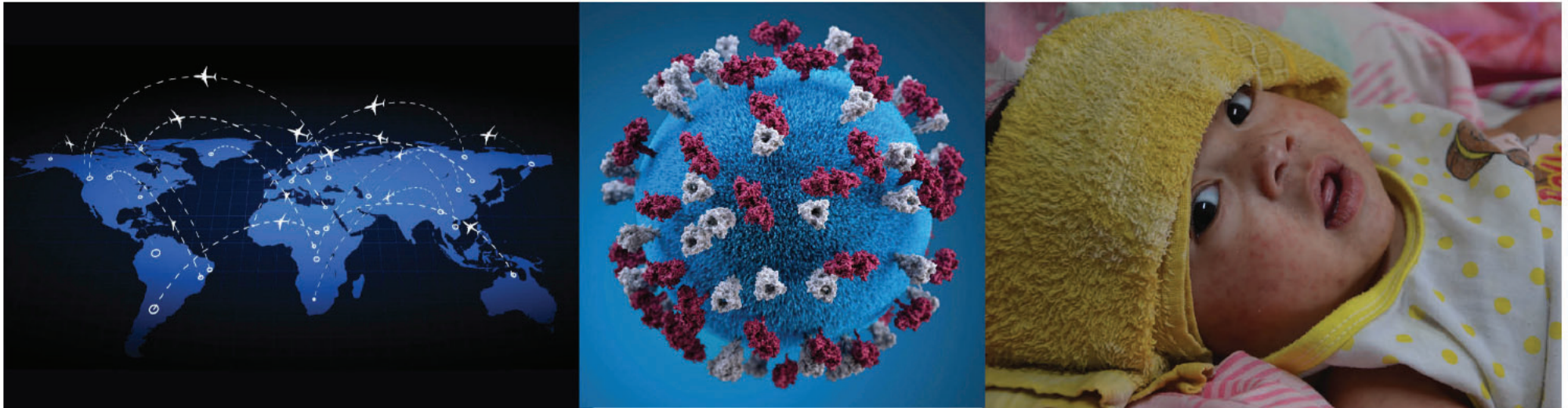


**Amanda Cohn, MD
(CAPT USPHS)
Chief Medical Officer
National Centers for Immunization
and Respiratory Diseases, CDC**

Acknowledgements to: *Debra Blog, Sarah Brazzell, Dylsia Cruz, Paula Erikson, Adriana Joseph, Brenda Holmes, Marissa Langdon-Embry, Luis Luque, Kerri McManhan, Holly Patrick, Allison Schneider, Jacki Silva, Tiffany Smith, Jeanette St. Pierre, Barbara Sutton, & Jane Zucker*

CDC PUBLIC HEALTH GRAND ROUNDS

Measles – Maintaining Disease Elimination and Enhancing Vaccine Confidence

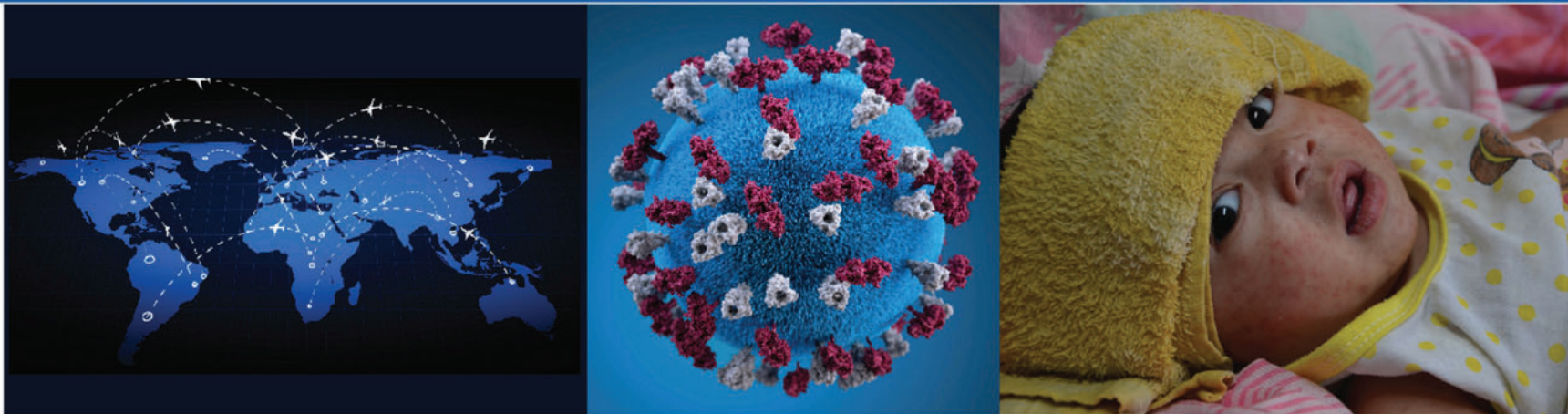


Dr. Jay C. Butler, CDC's Deputy Director for Infectious Diseases



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

Measles in the United States



Manisha Patel, MD, MS (CDR USPHS)
Medical Officer, Domestic Measles Team Lead
National Center for Immunization and Respiratory Diseases, CDC



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

Characteristics of Measles

- Most contagious of the vaccine preventable diseases ($R_0 = 12\text{--}16$)
- Acute viral rash illness
 - High fever, cough, coryza, conjunctivitis
- Incubation period: 10–14 days
- Infectious period: 4 days prior through 4 days after rash onset



Measles complications



- Diarrhea (8%)
- Otitis media (7%–9%)
- Pneumonia (1%–6%)
- Hospitalized (10%–25%)
- Encephalitis (1 per 1,000)
- Death (1–3 per 1,000)
- Subacute sclerosing panencephalitis (1 per 5,000–10,000)

Measles, Mumps, Rubella (MMR) Vaccine

➤ Vaccine effectiveness (VE)

- 1 dose of MMR: ~93%
- 2 doses of MMR: ~97%

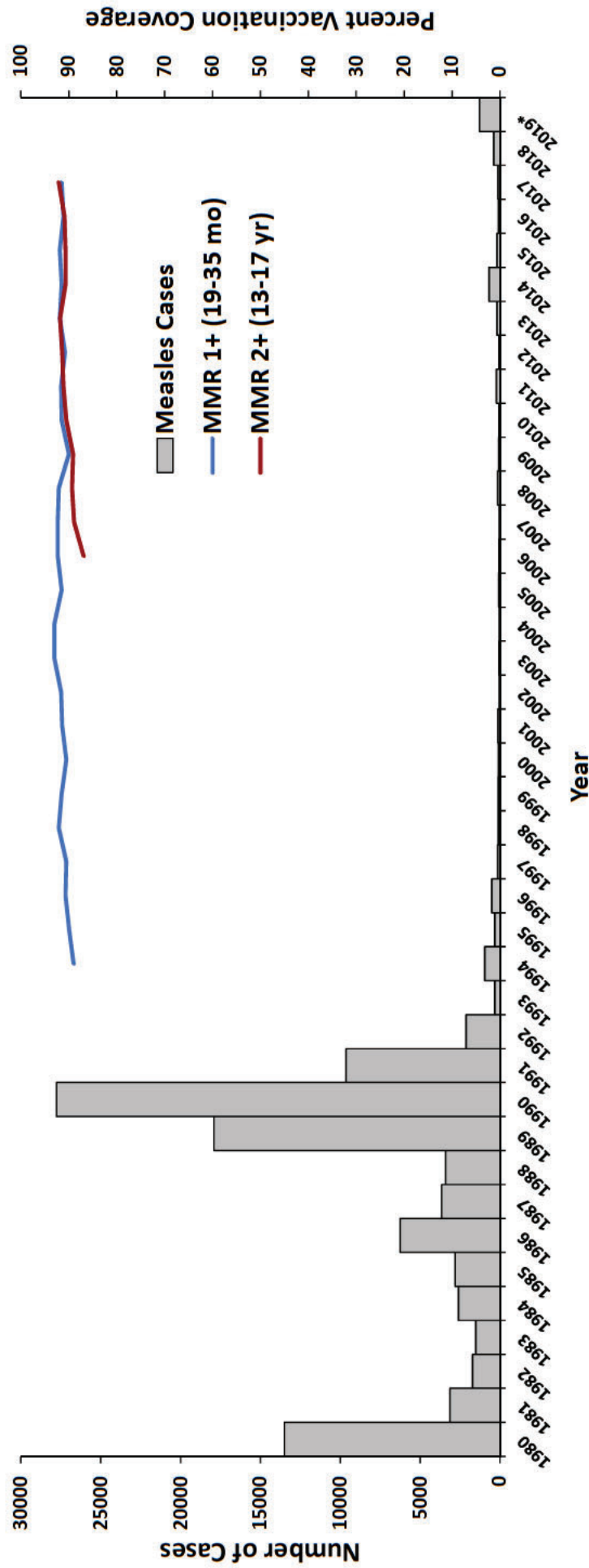
➤ Excellent safety profile over past 50 years

- Common side effects are usually mild and resolve spontaneously
- Serious adverse events are extremely rare

Measles, Mumps, Rubella (MMR) Vaccine Recommendations

- **Children and adolescents need TWO doses of MMR**
 - First dose at 12 to 15 months of age, and second dose at 4 to 6 years of age
- **Most adults need only ONE dose of MMR**
 - Two doses are recommended for adults at HIGH RISK for exposure, including healthcare personnel, post-high school students, international travelers
- **Infants 6–11 months of age traveling internationally need ONE dose**

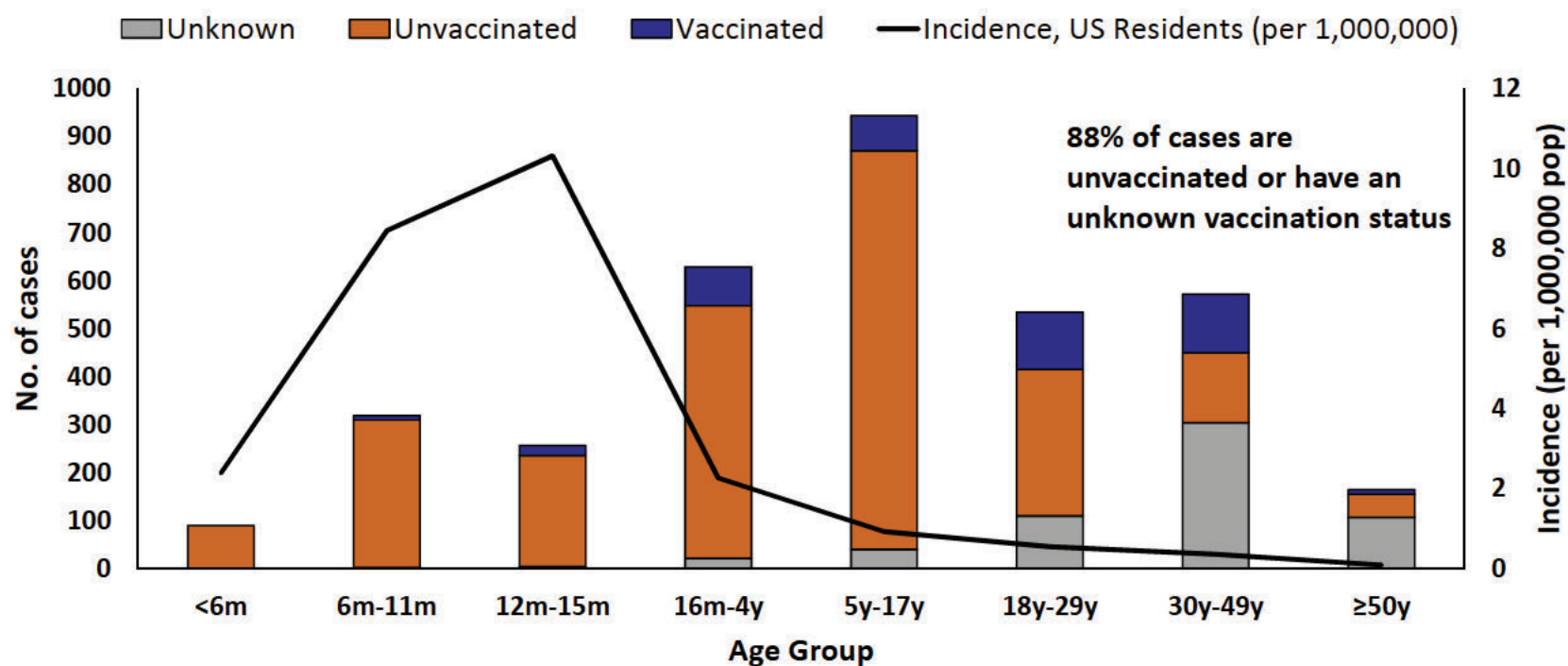
High MMR coverage in the United States led to elimination of measles in 2000



*Source: National Notifiable Diseases Surveillance System (passive surveillance); data as of January 31, 2020; National Immunization Survey, CDC

Most measles cases in the United States are among unvaccinated people

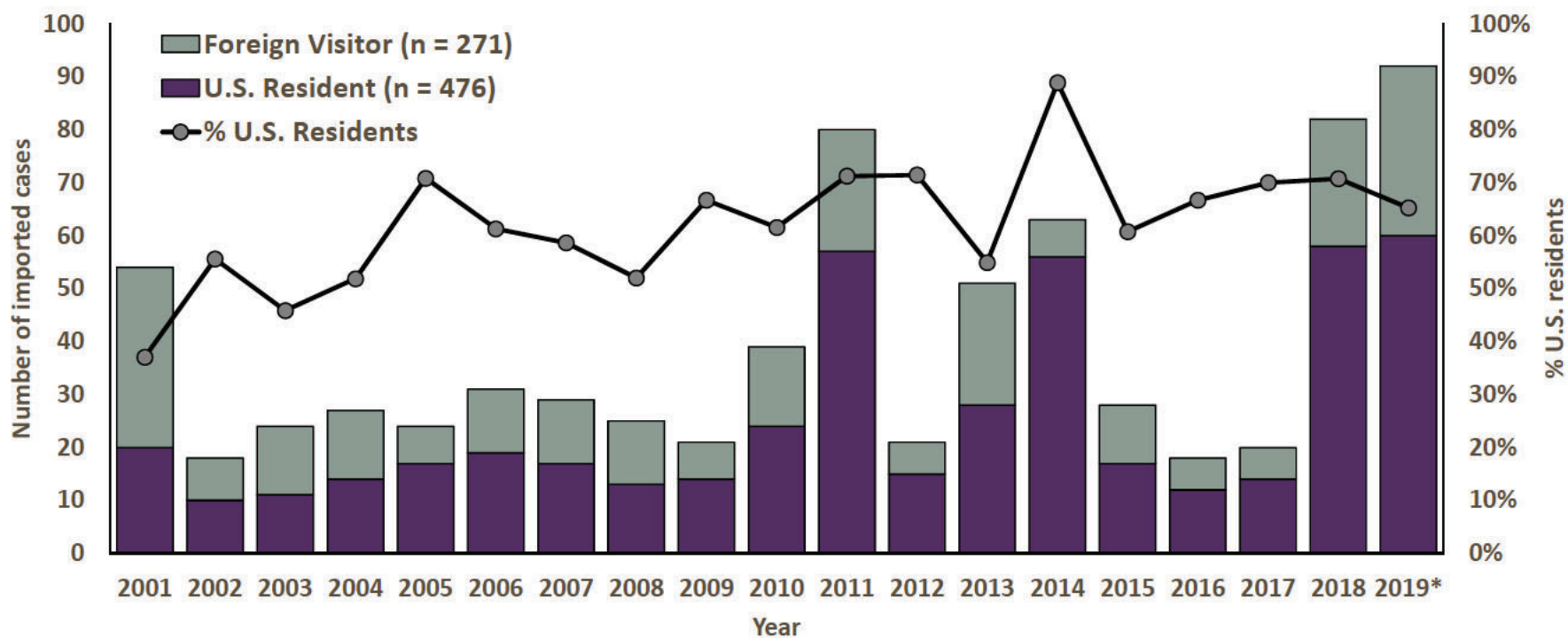
Measles cases by vaccination status and incidence rate, United States, 2001–2019 (N=3,881)



*Source: National Notifiable Diseases Surveillance System (passive surveillance); data as of January 31, 2020

Majority of measles importations are among U.S residents who traveled abroad

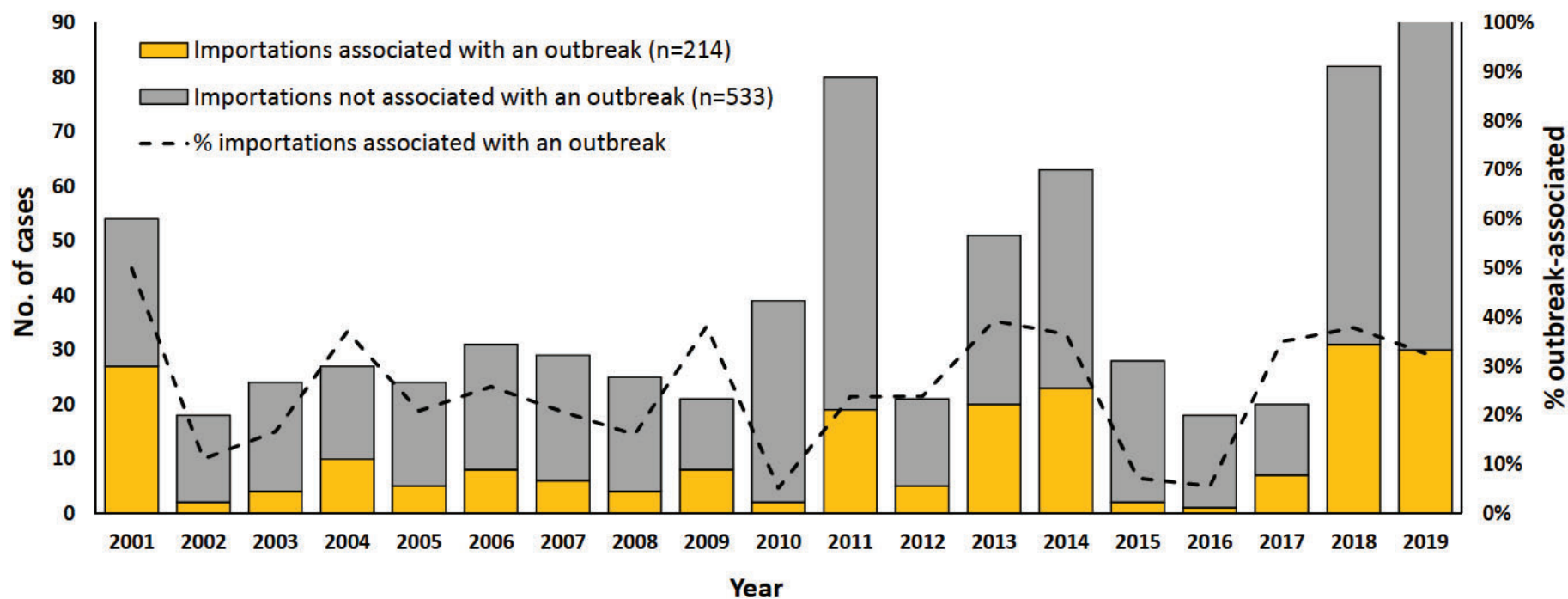
Measles cases by residential status, United States, 2001–2019 (N=747)



*Source: National Notifiable Diseases Surveillance System (passive surveillance); data as of January 31, 2020

Most U.S. importations are NOT associated with outbreaks

Outbreak vs. not outbreak-associated international importations, U.S., 2001–2019 (N=747)

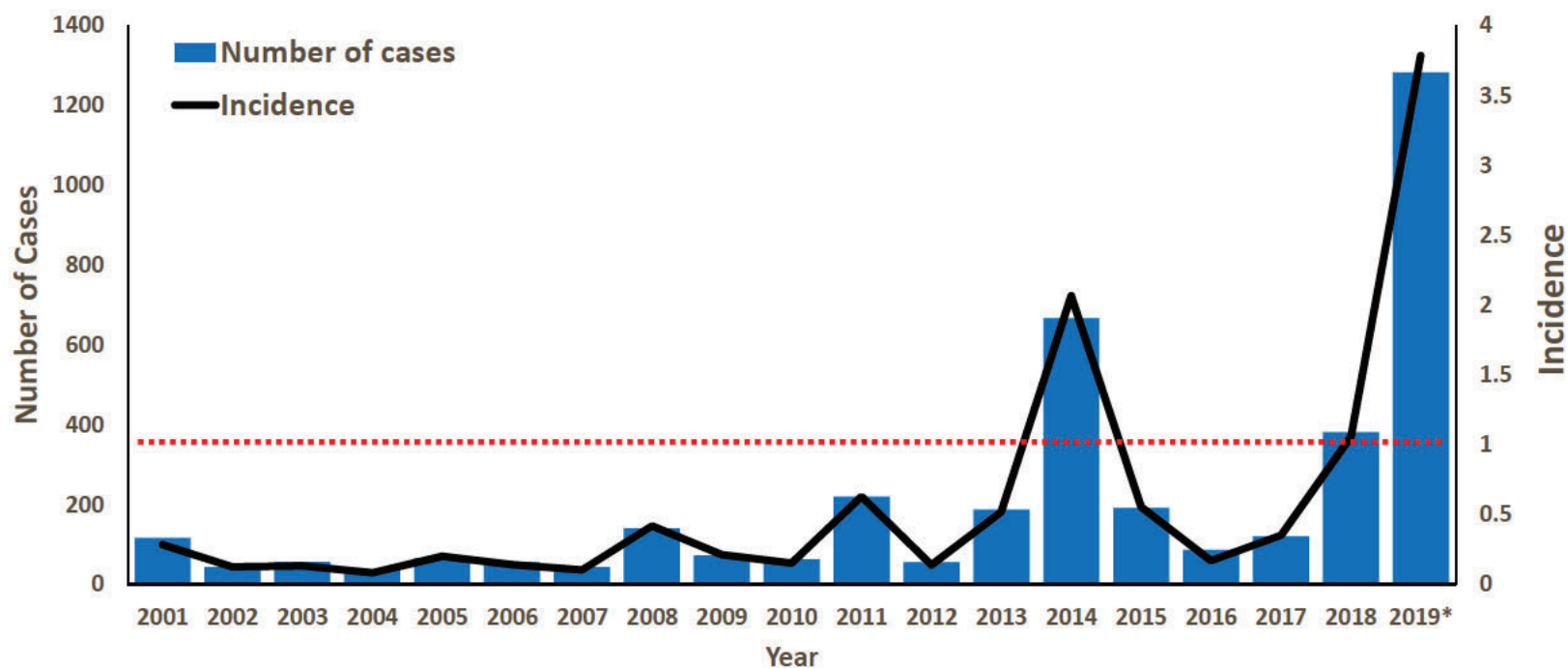


Median 28 importations per year, range 18–92

*Source: National Notifiable Diseases Surveillance System (passive surveillance); data as of January 31, 2020

The United States has seen a recent increase in measles

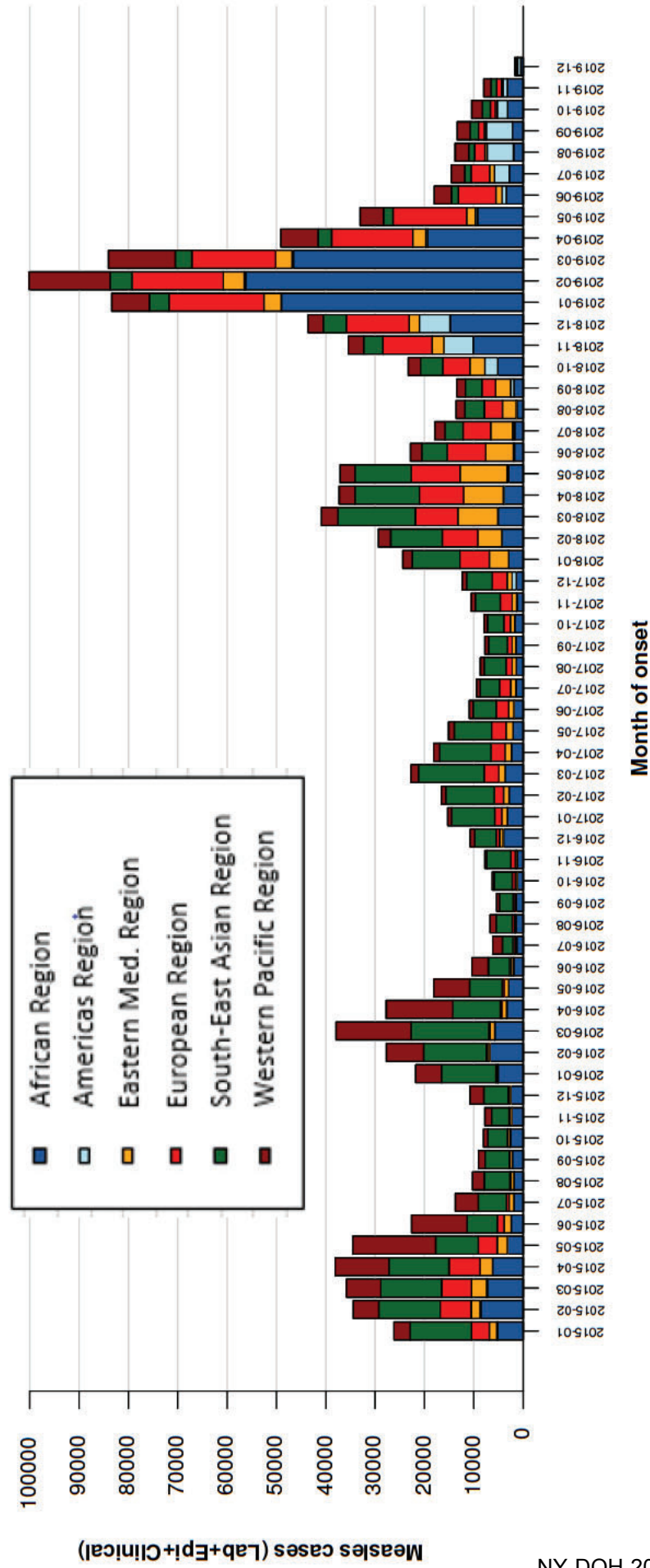
Number of reported measles cases, United States, 2001–2019* (N=3,881)



Median of 86 cases/year (range: 37–1,282)

*Source: National Notifiable Diseases Surveillance System (passive surveillance); data as of January 31, 2020

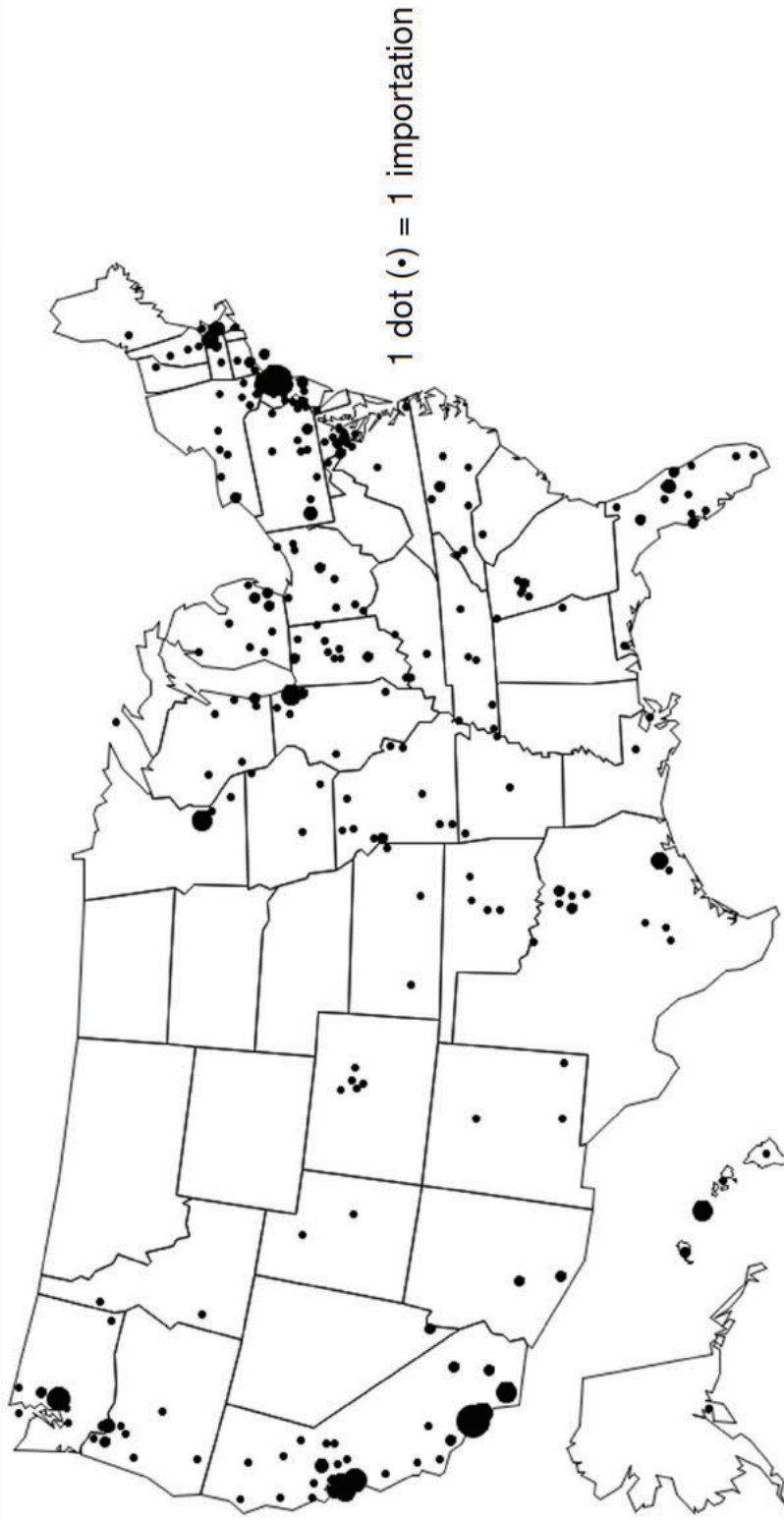
Global measles cases tripled in 2019



*Source: WHO:

https://www.who.int/immunization/monitoring_surveillance_burden/vpd/surveillance_type/active/measles_monthlydata/en/

Wide geographic distribution of measles importations, United States, 2001–2019 (N=747)

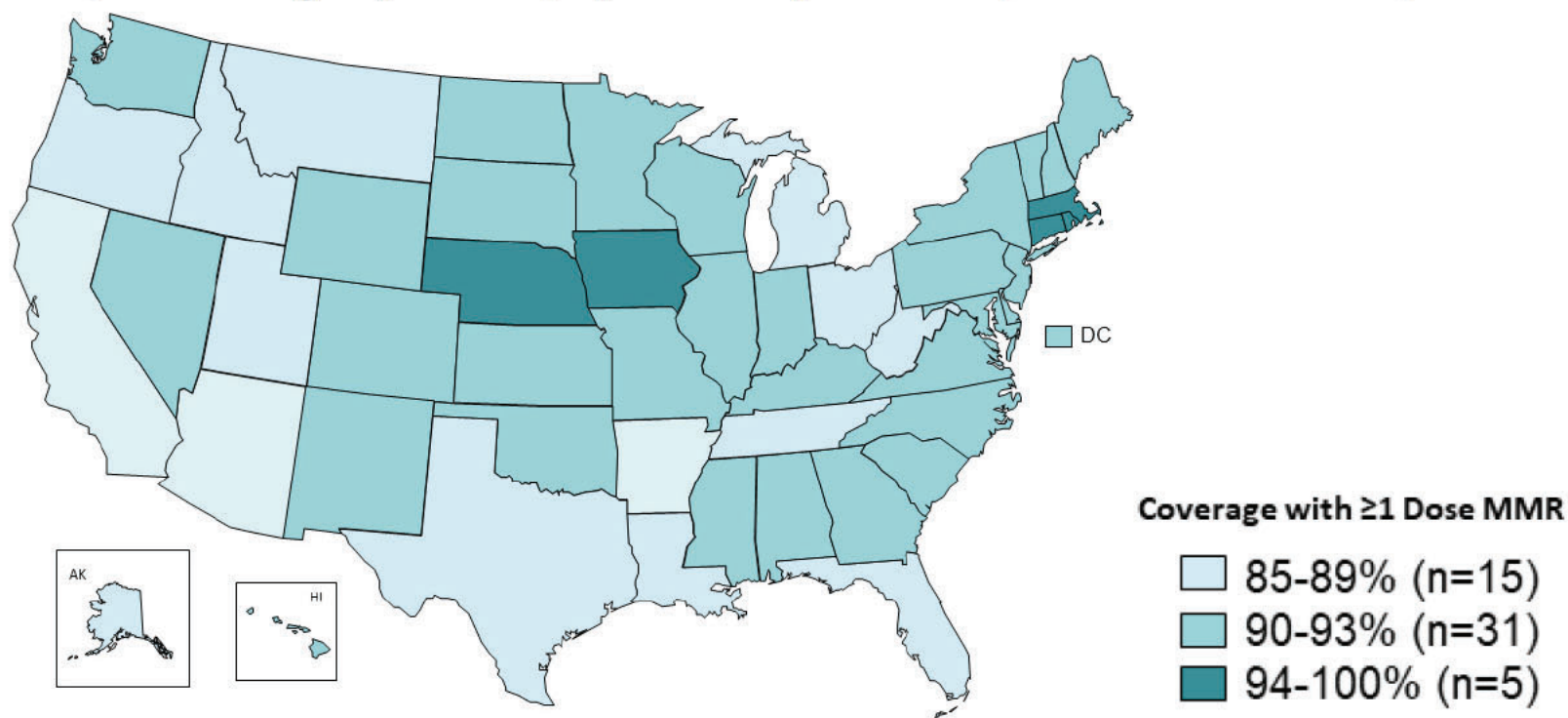


Median of 28 importations/year (range, 18 to 92)

*Source: National Notifiable Diseases Surveillance System (passive surveillance); data as of January 31, 2020

Variability in state and local MMR vaccine coverage can result in populations at risk for measles outbreaks

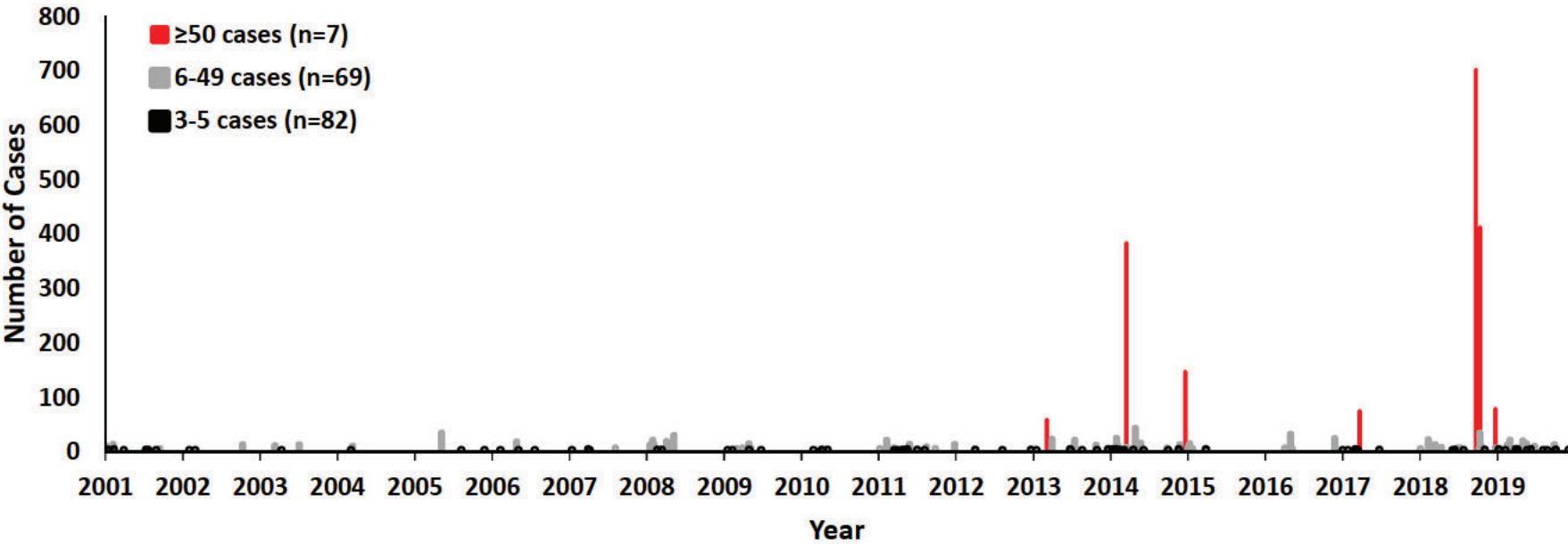
≥1 Dose MMR Vaccination Coverage by 24 Months, NIS-Child, U.S. 2013 to 2014 Combined Birth Years



Source: National Immunization Survey

Most US measles outbreaks have been of limited size and duration – Larger and more sustained outbreaks have been observed more recently

Number and size of measles outbreaks, U.S., 2001–2019 (N=158 outbreaks)



Number of outbreaks: Median of 4 outbreaks/year (range, 2 to 25)
 Size: Median of 5 cases/outbreak (range, 3 to 702)
 Duration: Median 23 days/outbreak (range, 3 to 322)

*Outbreaks are defined as ≥3 cases linked in time and place

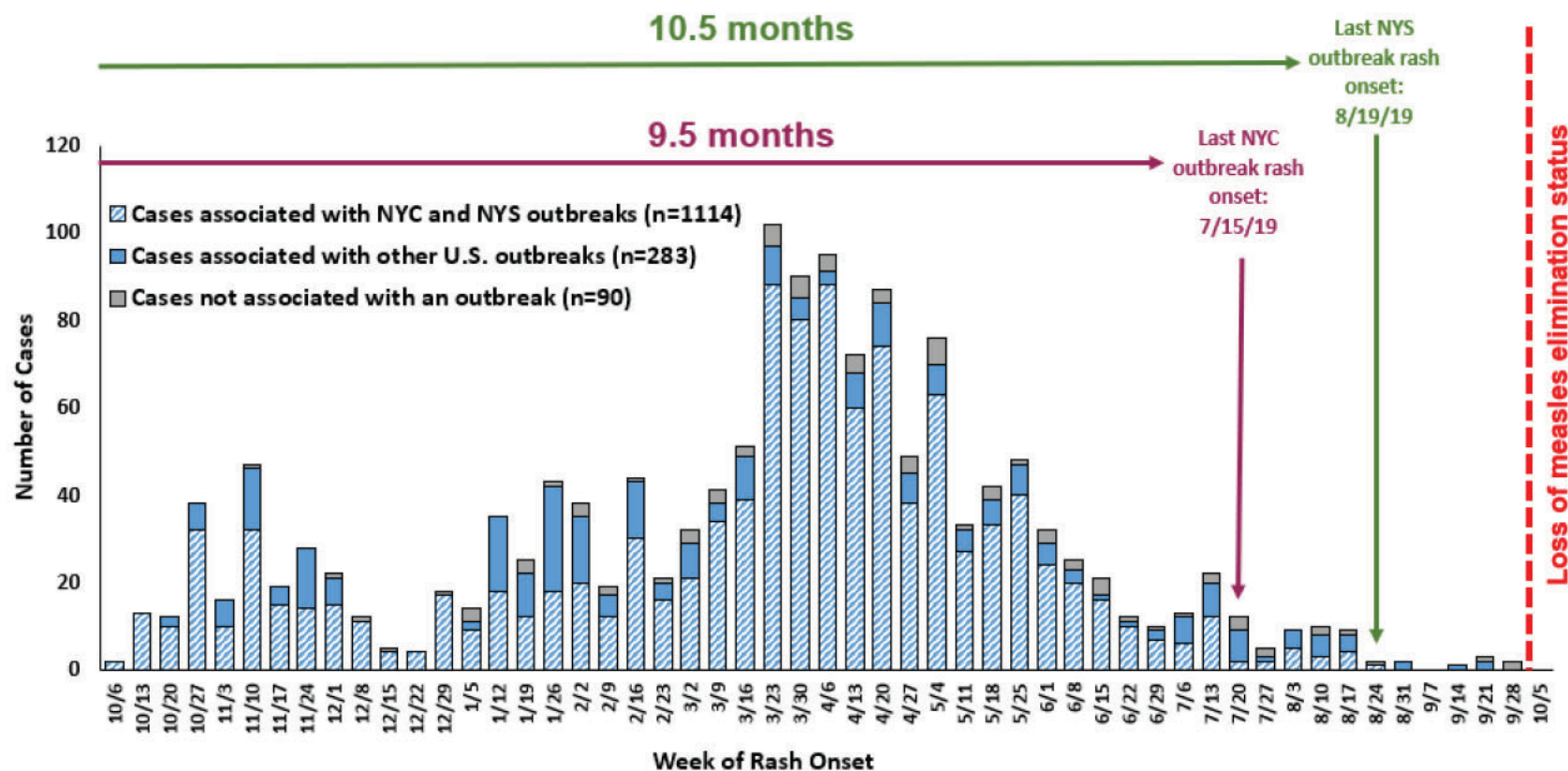
Source: National Notifiable Diseases Surveillance System (passive surveillance); data as of January 31, 2020

Largest measles outbreaks occurred within under vaccinated close-knit communities

Year	State	Source (genotype)	Community	Cases	Duration (months)
2013	NYC	UK (D8)	Orthodox Jewish	59	2.9
2014	OH	Philippines (D9)	Amish	383	4
2017	MN	Unknown (B3)	Somali	75	3.8
2014/2015	CA + 7 states	Unknown (B3)	Various	147	2.3
2018/2019	WA + 2 states	Ukraine (D8)	Ukrainian Russian Moldovan	78	2.5
2018/2019	NY, NYC + 4 states	Israel/Ukraine (D8)	Orthodox Jewish	1,114	10

Measles outbreaks in New York threatened measles elimination status in the United States

Number of reported measles cases (N=1,487), by week of rash onset, United States, September 30, 2018—October 1, 2019

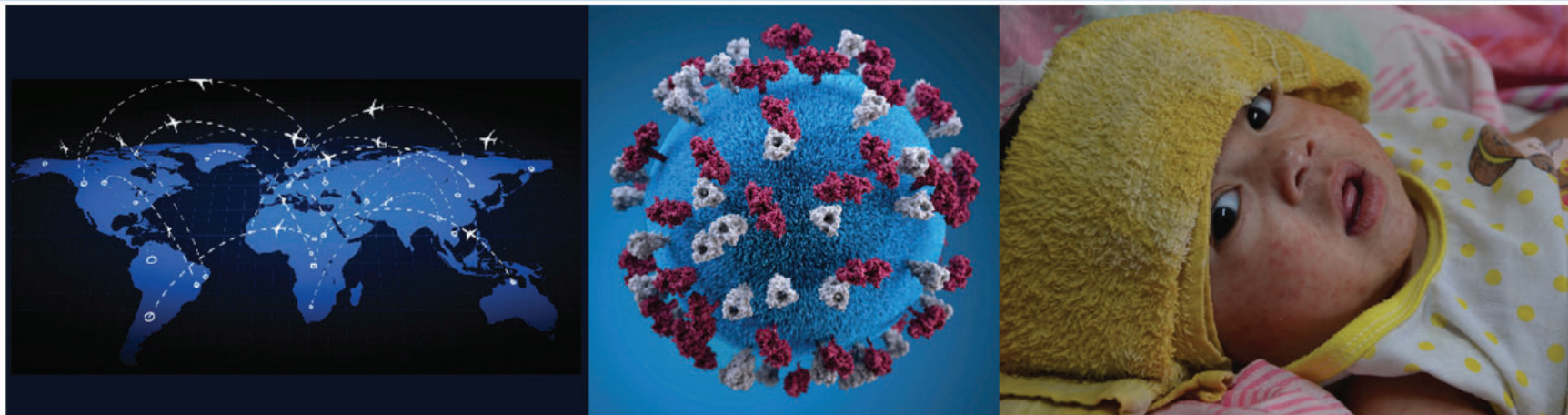


*Source: National update on Measles Cases and Outbreaks – United States, January 1 – October 1, 2019, MMWR, October 4, 2019

Summary

- **Endemic measles has been eliminated in the United States since 2000**
 - However, measles cases continue to occur through global importations
 - Most importations are U.S. travelers who are not vaccinated
- **Recent epidemiology suggests larger and more sustained outbreaks compared to earlier post-elimination years**
- **Measles exploits pockets of under vaccination**
 - Multidisciplinary local response needed to prevent measles outbreaks

The 2018–2019 Measles Epidemic in New York State: Successes and Challenges



Howard A. Zucker, M.D., J.D.

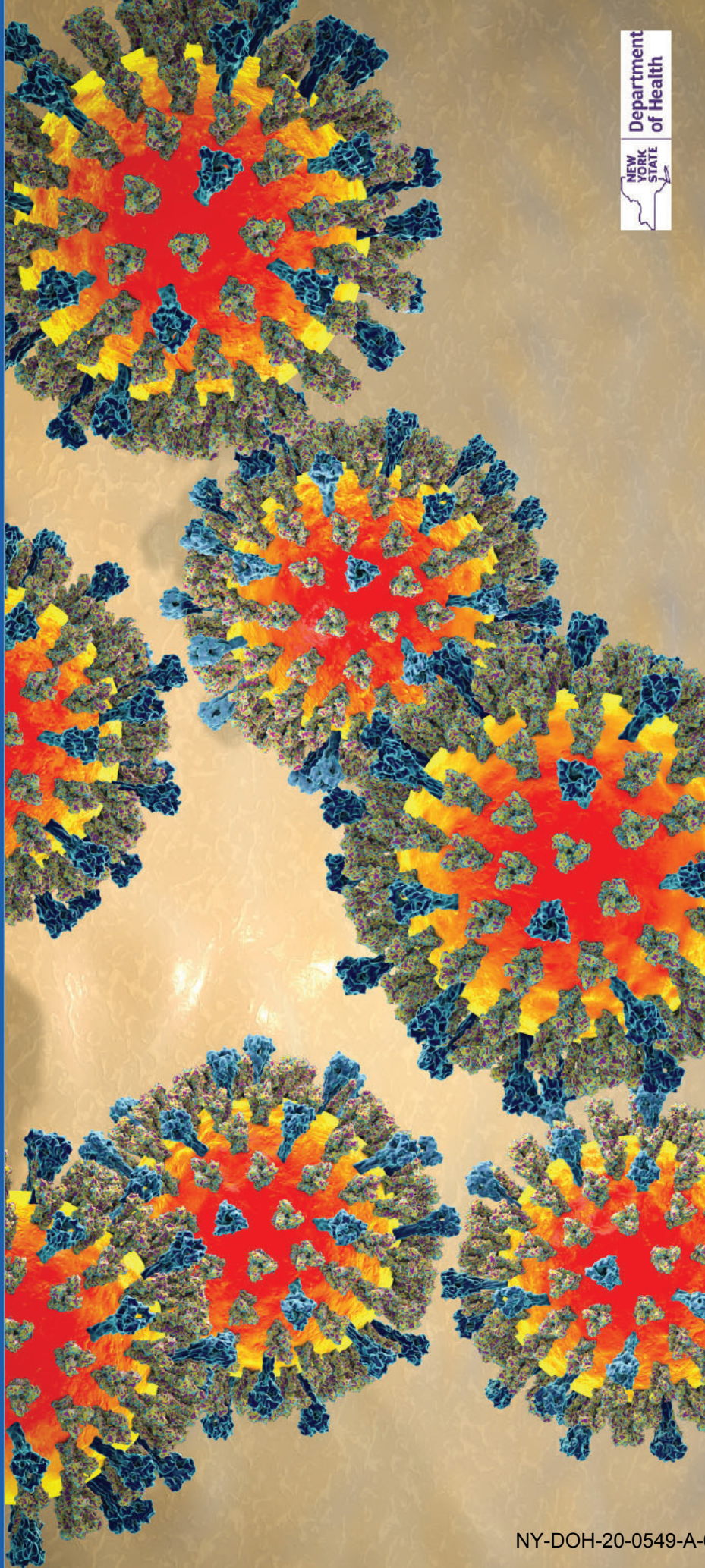
Commissioner

New York State Department of Health



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

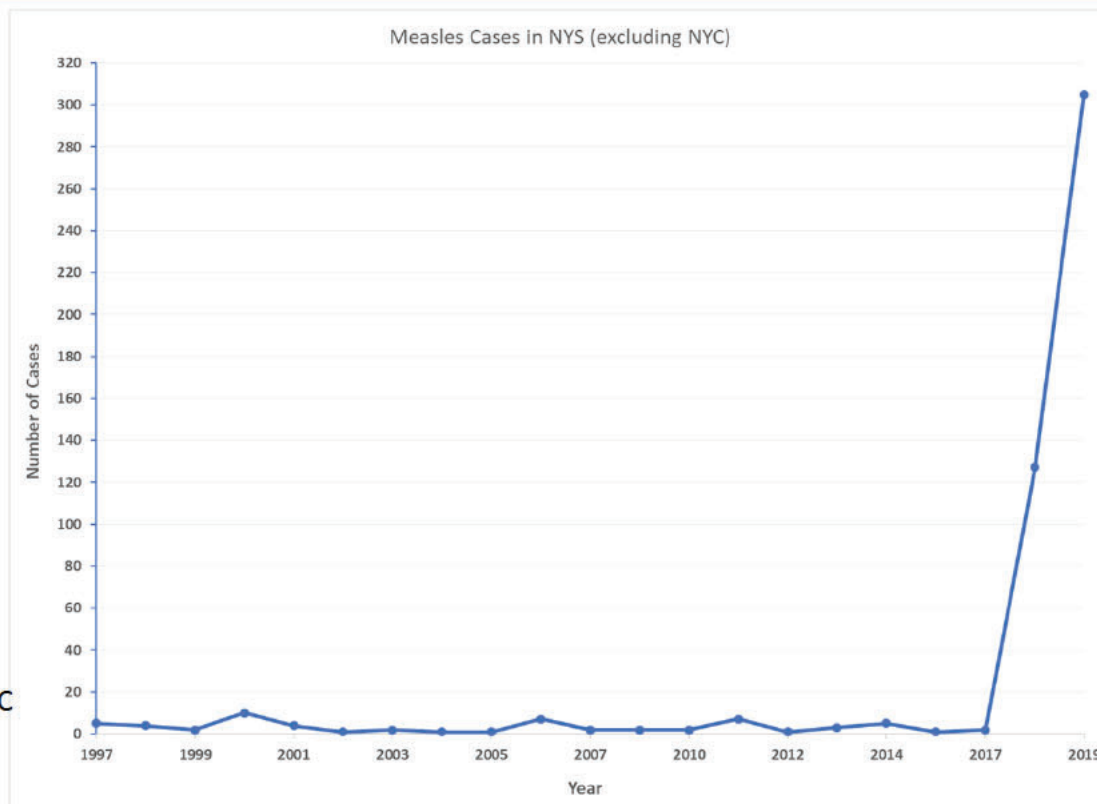
1. Measles and Public Health in New York State



New York's Leadership in Disease Prevention

- **1912:** U.S. begins routine reporting of measles cases; an average of 6,000 measles-related deaths are reported each year over next decade.
- **1914:** New York state's Antitoxin Laboratory designated as Division of Laboratories and Research, facilities that will later become known as **Wadsworth Center**.
- **1926:** Wadsworth develops nation's first system of standardized laboratory analysis for the diagnosis of human disease.
- **pre-1963:** Before licensing of measles vaccine, an estimated 400–500 U.S. residents died of measles each year.

Measles Cases in New York State, 1997–2019*



*As of 12/17/2019; excluding NYC

2. The 2018–2019 Outbreak



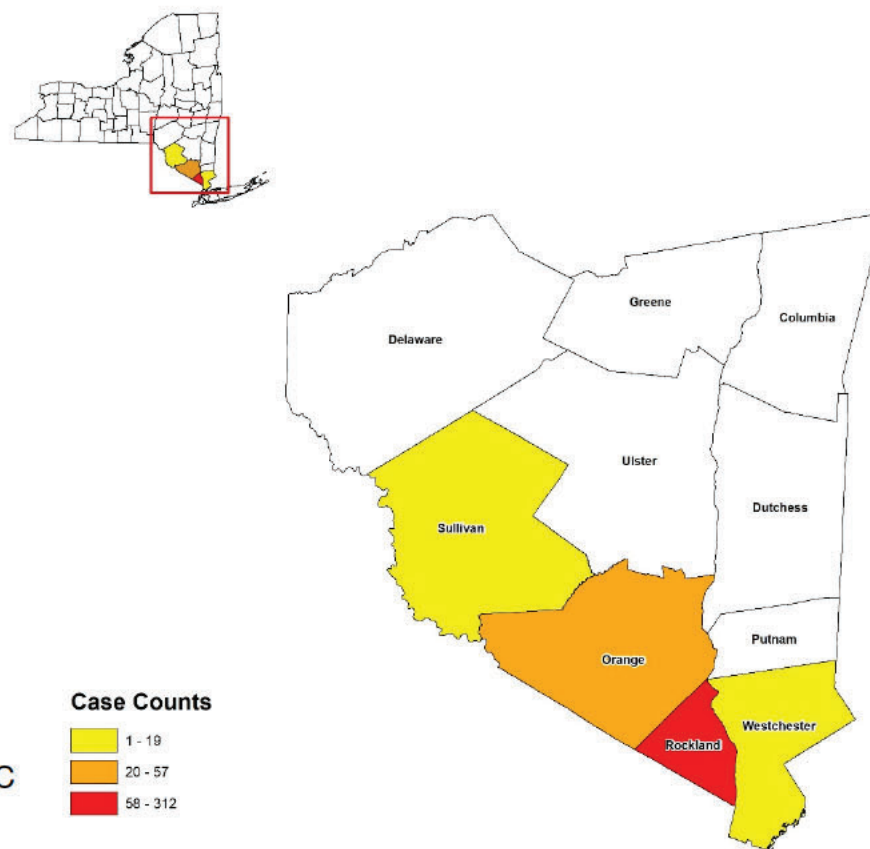
Initial Cases in the Lower Hudson

- **October 1, 2018:** Measles outbreak outside New York City begins in Rockland County when teenager visiting from Israel falls ill during services at local synagogue.
- **October 2018:** Six additional measles cases imported from Israel, including 4 people from one family who become ill at roughly the same time.
- **December 2018–April 2, 2019:** Three further measles importations bring internationally imported cases to 10 during outbreak.
- Outbreak encompasses **4 counties** outside of New York City, all of which have Orthodox Jewish communities.

Measles Outbreak Overview

- **October 1, 2018–October 3, 2019:** A total of **406 people** infected with measles in Rockland (312), Orange (57), Sullivan (19), and Westchester (18) counties.
- Most cases reported in under-vaccinated, close-knit Orthodox Jewish communities.
- **October 1, 2018–October 3, 2019:** county providers administered nearly **85,000 MMR vaccinations**, a 77% increase from the same period during the prior year.
- **October 2019:** County health officials and New York State Department of Health declare outbreak concluded in all 4 counties.

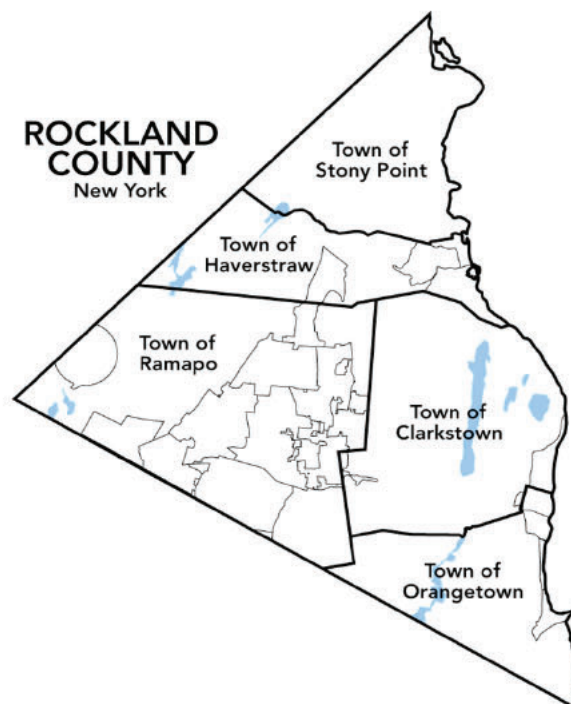
Measles Outbreak Cases by County*



*0/1/2018 – 8/19/2019; excluding NYC

Rockland County as Measles Ground Zero

- **312 cases** confirmed—about 1 in every 1,000 residents.
- Most cases were unvaccinated individuals.
- Nearly **30,000 doses of MMR vaccine** administered during outbreak—3X rate from the same period in the prior year.



Local Heroes: Rockland County Department of Health

“In the beginning, it was a 24/7 operation. The weekends, the nights, the holidays—it didn’t matter.

We lived and breathed measles. We fell asleep thinking of measles, and we woke up thinking of measles.”

— **Dr. Patricia Ruppert**,
Rockland County Health
Commissioner



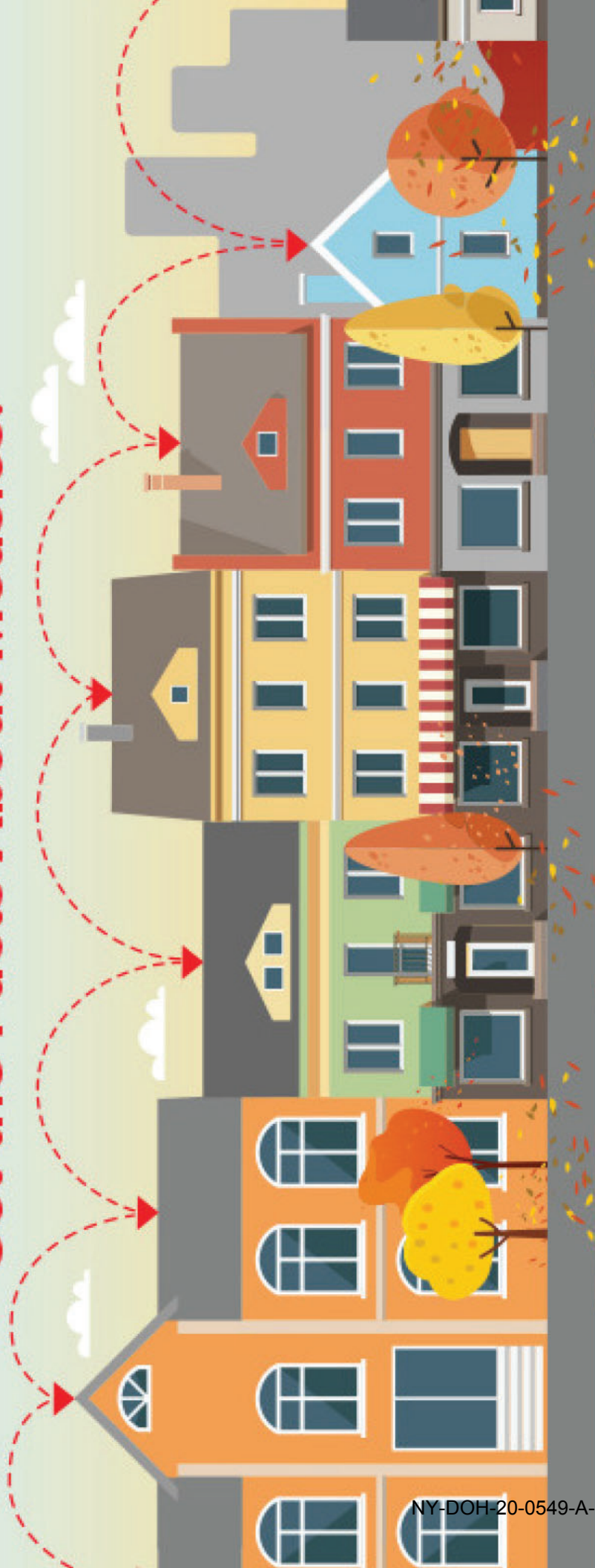
Local Heroes: Refuah Health Center

- Federally Qualified Health Center (FQHC) that provides healthcare to many in Rockland County's Orthodox Jewish community.
- Treated the Israeli boy who was outbreak's index case.
- Doctors and nurses worked closely with department and county officials to vaccinate the unvaccinated.



3. The New York State Response

Get the Facts About Measles.



Department of Health Mobilization Strategy



- Department's **Incident Management System** activated from start of outbreak
- Healthcare Outreach and Communication
- Community Education and Outreach
- Preventing Spread in Schools and at Summer Camps
- New York State Legislative Action

Healthcare Outreach and Communication

- Issued advisories, held conference calls and forums
- Made detailing visits to more than 30 medical practices, urgent care centers, and hospitals
- Provided vaccine to affected counties
- Coordinated specimen lab testing at Wadsworth Center
- Distributed educational materials for patients and families
- Collaborated with Refuah FQHC in Rockland County throughout outbreak

Community Education and Outreach

Printed Educational Materials

- Developed flyers, posters, information postings at malls and highway rest stops, and articles in local publications because digital communication was deemed ineffective for reaching affected demographic.
- Ensured that printed materials were available in English and Yiddish.
- Printed and mailed 90,000 copies of booklets on measles and vaccination to households in affected ZIP codes.
- Distributed 55,000 door hangers to households in affected ZIP codes.

Meetings, Forums, and Conference Calls

- Held conference calls with women in affected communities.
- Met with community, religious and educational leaders in affected counties.

Preventing Spread among Children

In Schools

- Unvaccinated children not admitted to schools or day care centers in outbreak areas, some for entire outbreak.
- Each school in outbreak areas required to confirm compliance weekly. Most schools audited and several fined for noncompliance.
- Rockland County denied unvaccinated children admittance to all schools near schools with measles cases.

At peak of outbreak, Rockland denied 6,000 unvaccinated children entry to 60 schools.

At Summer Camps

- Unvaccinated campers not admitted in high-risk counties.
- Summer population in Sullivan County swells to about 300,000 (from 67,000) because of primarily Orthodox vacationers and campers from NYC.
- Despite this increase, all 300 camps in affected counties were audited.

New York State Legislative Action

- On June 13, 2019, Governor Cuomo signed legislation (S.2994A/A.2371) **removing nonmedical exemptions** from school vaccination requirements for New York state children.
- In August, the Department of Health joined the Office of Children and Family Services to issue **emergency regulations** providing physicians with clear, evidence-based guidance on determining when immunization may be detrimental to a child's health.

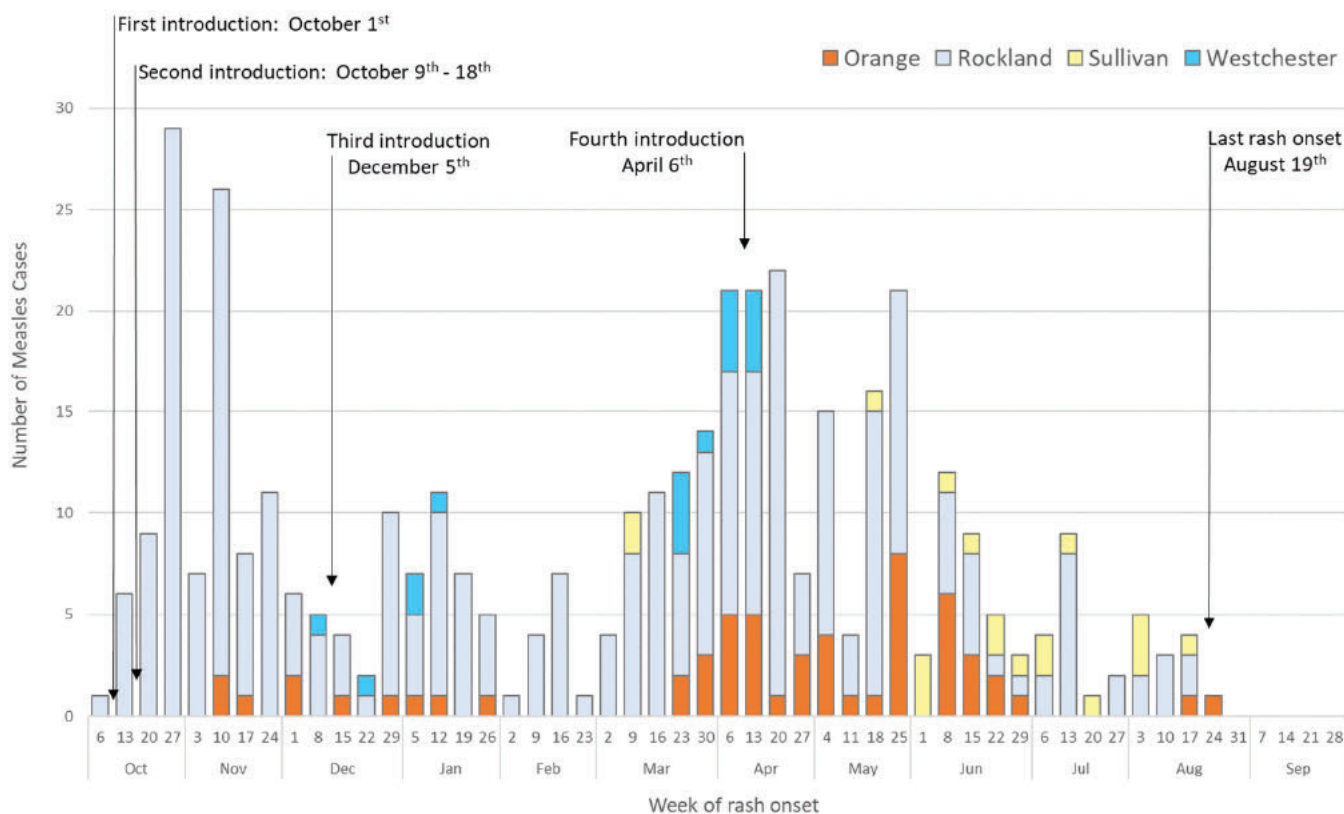


4. Data Analysis



Measles Outbreak Cases by Week of Rash Onset and County

Number of Measles Cases by Week of Rash Onset and County in the Hudson Valley, NYS,
October 1, 2018 – August 19, 2019 (N=406)*



Rates of Vaccination

- New York state has high MMR immunization coverage overall—96% among school-age children.
- Before outbreak, vaccination coverage for children age 1–18 in 4 most affected ZIP codes was **87.3%**.
- Vaccinations during outbreak primarily administered in private practices and FQHCs and public health–held clinics.
- By August 1, 2019, vaccination coverage for children age 1–18 in those ZIP codes increased to **98.3%**.

Measles Outbreak Cases by Age and Vaccination Status*

Age Group	Number of MMR Doses				
	0	1	2	Unknown	Total
<6 months	17	0	0	0	17 (4%)
6-11 months	31	3	0	0	34 (8%)
1-4 years	110	14	3	7	134 (33%)
5-17 years	125	3	2	9	139 (34%)
18+ years	34	4	10	34	82 (20%)
Total	317 (78%)	24 (6%)	15 (4%)	50 (12%)	406

10/1/2018 – 8/19/2019; excluding NYC

Measles-Associated Complications in Outbreak

- No deaths or documented cases of encephalitis.
- 28 (7%) patients diagnosed with pneumonia.
- 28 (7%) patients hospitalized; 20 of them (71%) were children, with 6 (30%) (ranging in age from 1 day to 7 years) admitted to ICU.
- Two women who had measles while pregnant gave birth to preterm infants at 34 and 25 weeks' gestation. Both infants had congenital measles infection confirmed by measles PCR testing.

5. What We Learned

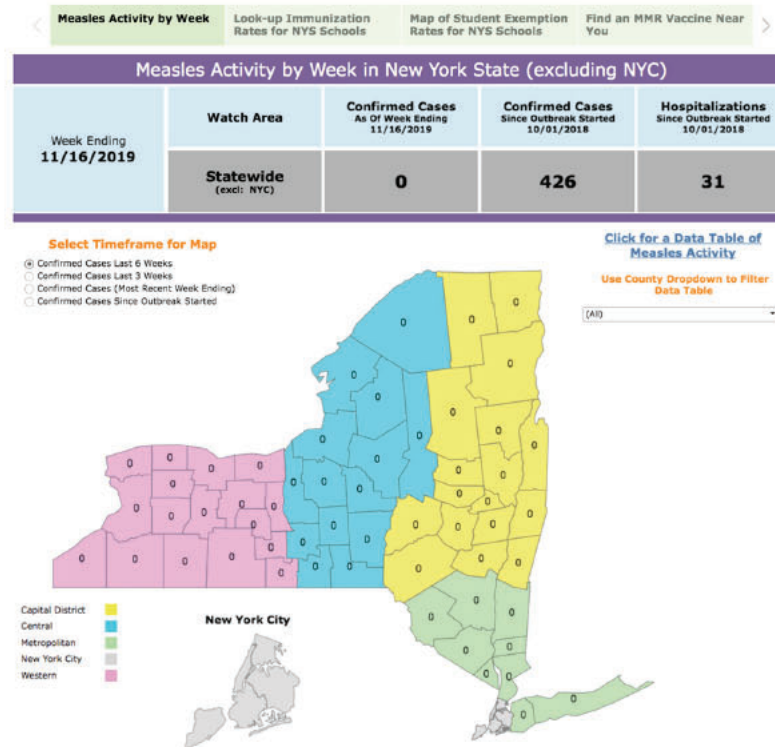


Factors Contributing to Outbreak

- Vaccine hesitancy
- Targeted anti-vaccine activity and misinformation
- Multiple importations following large outbreak in Israel
- Large gatherings
- Close-knit communities
- Large families
- Underreporting and unidentified transmission
- Families did not always seek medical care
- Lab testing limitations

Department Action on Measles

New York State Measles Watch



Critical Steps to Prevent Future Outbreaks



PARENTS: NYS School Vaccination Requirements Have Changed

Nonmedical exemptions to school vaccination requirements have ended for children attending day care and pre-K through 12th grade in New York State. This includes all public, private, and religious schools. Religious exemptions are no longer allowed.

Children with nonmedical exemptions must now be vaccinated to attend or remain in school.

Students who already have all required school vaccinations, and students with a valid medical exemption from a physician, are not affected by this change.



IMPORTANT VACCINATION DEADLINES:

• **Within 14 days of the first day of school or day care** – children must receive the first age-appropriate dose in each immunization series to attend or remain in school or day care.

• **Within 30 days after the first day of school or day care** – parents or guardians must show that they have appointments for the next required follow-up doses for their child. Deadlines for follow-up doses depend on the vaccine.



What vaccines does my child need?

Ask your health care provider. Requirements will differ based on your child's age and any previous vaccinations.



Is it safe for my child to have more than one shot at a time?

Scientific data show that getting multiple vaccines at the same time is safe. It also means fewer doctor's office visits which can be less stressful for your child. Visit health.ny.gov/vaccinesafety to learn more.



Tips to help your child relax at their next shot visit:
www.cdc.gov/vaccines/parents/visit/less-stressful.html
www.cdc.gov/vaccines/parents/tools/tips-factsheet.pdf



- Ongoing **vigilance** regarding vaccine hesitancy
- Strong **partnerships** and communication channels with county health departments and local healthcare providers
- Removing **nonmedical exemptions** from school vaccination requirements across New York state

Outbreak All-Stars

New York State Department of Health

Debra Blog, Dina Hoefer, Elizabeth Rausch-Phung, Elizabeth Dufort, Patrick Bryant, Nina Ahmad, Lou Smith, Rachel Wester, Kirsten St. George, Jamie Sommer, Karen Southwick, Candace Noonan-Toly, Kimberly Carrasco, Dylan Johns, Stephanie Ostrowski, Eleanor Adams, Brad Hutton

Rockland County Department of Health

Patricia Ruppert, Maria Souto, Kevin McKay, Tatiana Dolinsky

Orange County Department of Health

Lisette McNulty, Irina Gelman, Debbie Fagan

Westchester County Department of Health

Ada Huang, Toby Levin, Sherlita Amler

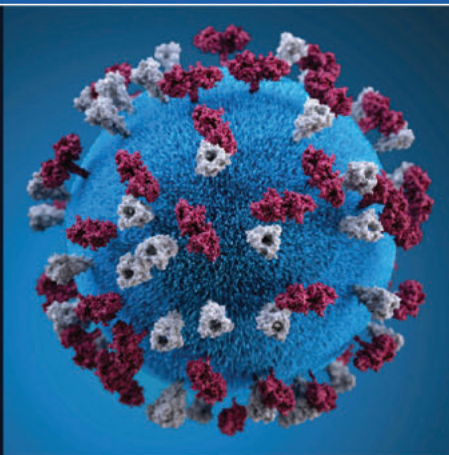
Sullivan County Department of Health

Nancy McGraw

CDC

Manisha Patel, Paul Gastanaduy, Robert McDonald

2018–2019 measles outbreak: The New York City experience



Oxiris Barbot, MD

Commissioner

New York City Department of Health and Mental Hygiene



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

OVERVIEW

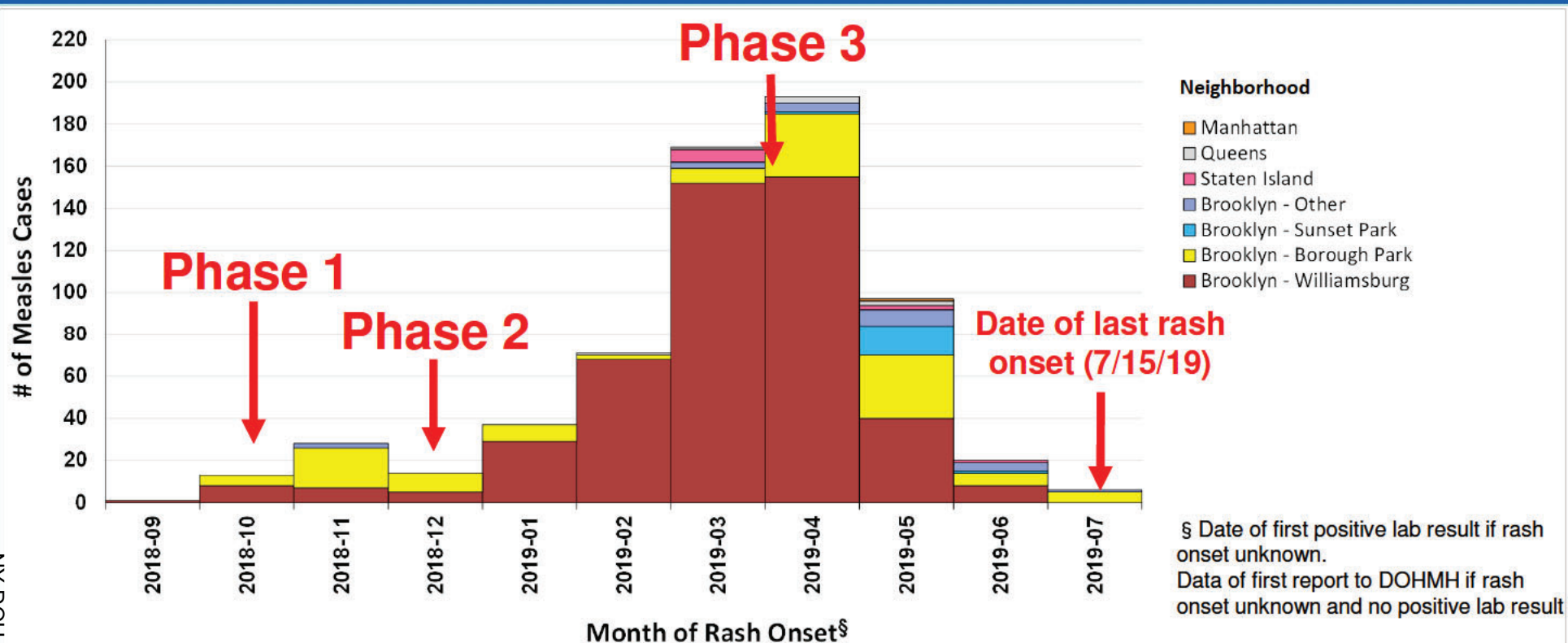
- Geographic distribution and demographic description of cases
- Complications among affected persons
- Factors that led to the outbreak
- Twofold DOHMH response:
 - Measles virus
 - Vaccine misinformation
- Lessons learned
- Future challenges

LOCATIONS OF MEASLES OUTBREAKS

- First case had rash onset on Sept. 30, 2018
 - Unvaccinated child who returned from Israel
- Centered in two Orthodox Jewish neighborhoods in Brooklyn



MEASLES CASES BY DATE OF RASH & NEIGHBORHOOD (N=649)



Source: NYC DOHMH surveillance data, as of 9/25/19.

DEMOGRAPHICS OF CASES (N=649)

Characteristics**n (%)****Age Category:**

<1 year 102 (16)

1 to 4 years 277 (43)

5 to 19 years 146 (22)

 $\geq$ 18 years 124 (19)

VACCINATION STATUS OF CASES (N=649)

- Unvaccinated: 476 (86%)*
 - Age <12 months: 100
 - Age $\geq$ 12 months: 376 Preventable Cases
- Vaccinated: 79 (14%)*
 - 1 prior MMR: 46
 - 2 prior MMR: 33
- Unknown vaccination history (primarily adults): 94

*% among cases with known vaccination status, as of December 20, 2019

PERSONS EXPERIENCING COMPLICATIONS

- Hospitalizations: 49 (8%)
 - 20 ICU admissions
- Pneumonia: 37 (6%)
- Otitis media: 63 (10%)
- Diarrhea: 92 (14%)
- No cases of encephalitis or deaths have occurred

WHY DID THIS OUTBREAK OCCUR?

- **Low herd immunity in a densely populated, relatively closed community with large young households**
 - Existing coverage low, vaccination delay until school enrollment
 - Religious exemptions have almost tripled in past 6 years
 - Citywide from 0.5% in 2012–13 to 1.5% in 2018–19
 - In Orthodox Jewish schools, from 0.7% in 2012–13 to 2.7% in 2018–19; some schools had religious exemptions as high as 28%

WHAT MADE THIS RESPONSE SO COMPLEX?

- Multiple importations (Israel, UK, Ukraine, NY, NJ)
- Multiple exposures (>20,000 exposures) and chains of transmission (>100 chains)
- Vaccine hesitancy fueled by vaccine misinformation cloaked in religious terms
- Parents not bringing children for care or providing exposure information, precluding control measures

DOHMH RESPONSE: MEASLES OUTBREAKS

1. Clinical
2. School or day care
3. Legal
4. Communication

DOHMH RESPONSE: MEASLES OUTBREAKS

CLINICAL

- Clinical and infection control consultation
- Technical assistance to facilities or providers serving the affected communities
- Assist with postexposure prophylaxis for exposed persons

SCHOOL AND CHILD CARE

- Exclusion of unvaccinated students with medical or religious exemptions from schools, communities with active measles cases

APRIL 9, 2019: PUBLIC HEALTH EMERGENCY DECLARED

- Every adult and child who lives, works, or resides in Williamsburg and has not received the MMR vaccine must be vaccinated
- Exception: People who demonstrate they are immune from measles or have a valid medical exemption
- Last public health emergency ordered people to get vaccinated against smallpox ~1901



DOHMH RESPONSE: MEASLES OUTBREAKS

LEGAL

- Five parents challenged vaccination order
- On April 18, 2019, Justice Lawrence Knipel denied motion for an injunction and dismissed their challenge finding:
 - Williamsburg at “the epicenter” of “the most significant spike in incidences in the United States in many years”
 - Petitioners unable to offer better, less restrictive alternative
 - Medical objections not supported by science
- Appellate Division denied temporary restraining order on April 30, 2019, and motion for preliminary injunction on May 13, 2019

DOHMH RESPONSE: VACCINATION MISINFORMATION

COMMUNICATION

- Community collaboration
 - Religious leaders
 - Met with rabbinical and community leaders, elected officials
 - Medical partnerships
 - Jewish Orthodox Women's Medical Association and Vaccine Task Force
 - Pediatric care practices
- Information disseminated through various outlets

DOHMH RESPONSE: VACCINATION MISINFORMATION

- WHO declared vaccine hesitancy as top 10 threat to global health
- Anti-vaxxers infiltrated ultra-Orthodox Jewish community
 - Robocalls and flyers conveying false information spread throughout community
 - **P**arents **E**ducating and **A**dvocating for **C**hildren's **H**earth, an anti-vaccine organization, led efforts to intensify vaccine hesitancy

DOHMH RESPONSE: “A SLICE OF PIE”

A
SLICE
OF
PIE

Parents Informed & Educated

Making PIEs Out of PEACH:
MMR EditionBringing Current and Reliable
Vaccine Information to Frum FamiliesA project of the EMES Initiative
May 2019

VACCINE SAFETY

How Do I Know Vaccines Are Safe?

Just like all drugs, vaccines undergo a lot of scrutiny before being approved. It takes many years, from the application process, all the way through all the stages of testing, to receive approval for use on humans. Once a vaccine is approved, that is not the end of the monitoring. Several organizations oversee the manufacturing, and continually gather information on all vaccines to ensure safety and effectiveness.

Here are some organizations that monitor vaccine safety:

The following organizations monitor vaccine safety: the Food and Drug Administration, Centers for Disease Control and Prevention, National Institutes of Health, and the Department of Defense, among others. There are surveillance systems to identify vaccine safety concerns, including: Vaccine Adverse Event Reporting System (VAERS), Vaccine Safety Datalink (VSD), Post-Licensure Rapid Immunization Safety Monitoring (PRISM), and the Clinical Immunization Safety Assessment (CISA) Project.

Anti-Vaxx Myth: There are no safety studies or any real way to know if vaccines are safe.

PIE: False. Vaccines are studied and monitored from the very beginning and go through years of safety testing in labs and clinical trials before they go to market. Once the vaccine is approved, the manufacturer tests batches of the vaccine for quality and safety before the FDA can recommend it for use. Once the vaccine goes to market, multiple agencies monitor its safety and provide additional checks. *Source:* HHS, 2017b

Anti-Vaxx Myth: “It is rare for a vaccine to be removed from circulation, no matter how much damage it is causing.”

PIE: False. As with any drug, not all adverse effects will occur during clinical trials. Therefore, once a vaccine is made available to the public, information is continually gathered to identify problems after marketing begins. Although vaccines rarely cause long-term harm, there have been a few cases where a specific vaccine was found to be unsafe once they were already in use. In these cases, the vaccine was immediately removed from circulation.

Source: HHS, 2017b; Offit, 2005; CDC, 2015

Is there any connection between autism and vaccines?

In 1998, a study by Andrew Wakefield, then a consultant gastroenterologist, was published in the *Lancet*, a British medical journal. He studied 12 children whose parents claimed they noticed behavioral regression and gastrointestinal symptoms after their children received the MMR vaccine. After publishing his study, Wakefield then held a press conference where he stated that the MMR vaccine was unsafe, and advocated the use of single-antigen vaccines (i.e., separating the measles, mumps, and rubella into three separate vaccines).

Source: Dyer 2010; Wakefield, 1998

Wakefield’s study, however, never concluded that MMR caused either autism or the gastrointestinal problems. To the contrary, Wakefield actually made the following statement in his study: **“We did not prove an association between measles, mumps, and rubella vaccine and the syndrome described.”** He also concluded that, “A genetic predisposition to autistic-spectrum disorders is suggested by over-representation in boys and a greater concordance rate in monozygotic [identical] than in dizygotic [fraternal/non-identical] twins.”

Source: Dyer 2010; Wakefield, 1998

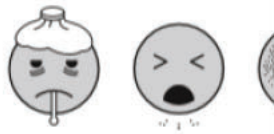
DOHMH RESPONSE: MEDIA CAMPAIGNS

ATTENTION MEASLES OUTBREAK

GET VACCINATED

IF YOU HAVE

fever, cough, red eyes,
runny nose and body



PLEASE CONTACT YOUR
DOCTOR IMMEDIATELY

NYC
Health

אין אינאיינעם אפשטעלן

מזעלס

מענטש מיט מזעלס קען אנשטעקן
מענטשן וואס זענען נישט אימיון.



ווערט היינט וואקסנירט.
ווערט נישט געוואקסנירט.

SPREAD THE TRUTH NOT MEASLES

There is no link between
autism and vaccines.

PROTECT YOURSELF, YOUR FAMILY AND YOUR COMMUNITY.
GET VACCINATED TODAY.
CONTACT YOUR DOCTOR IMMEDIATELY.

NYC
Health

TOGETHER WE CAN STOP MEASLES

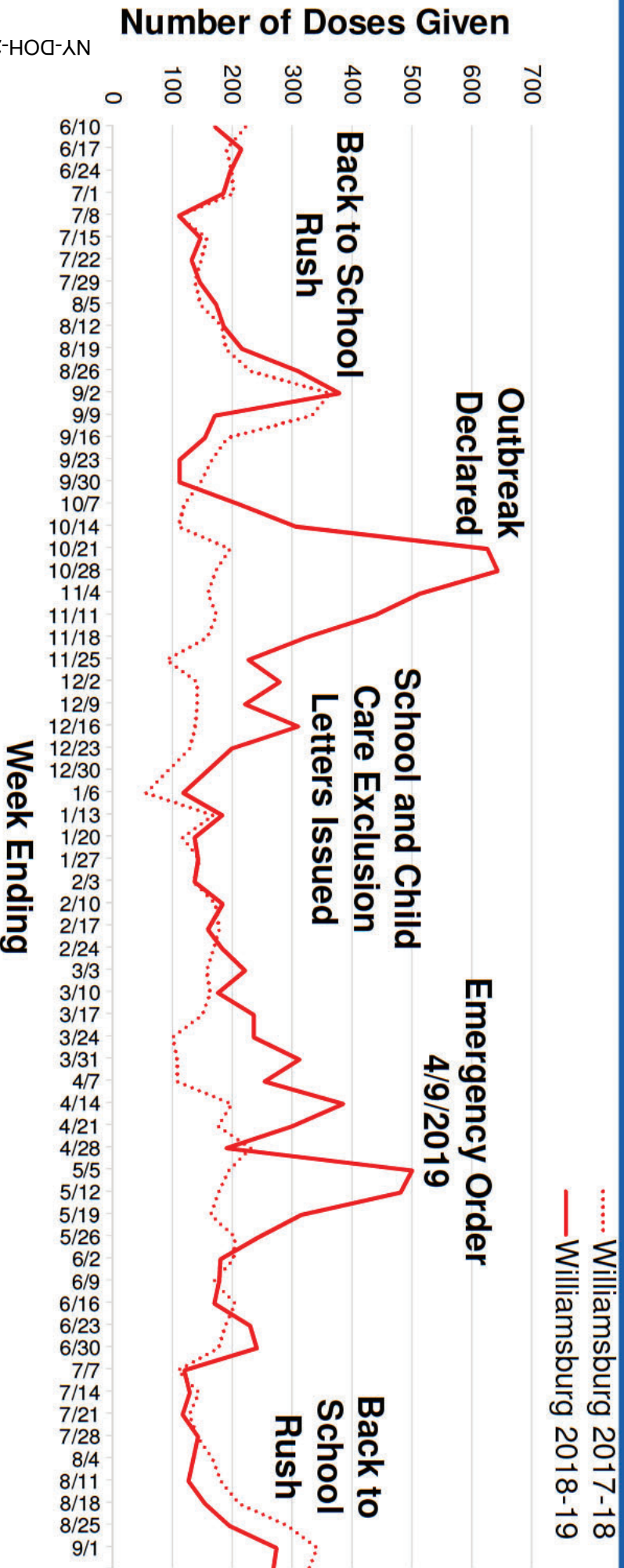
One person with measles can infect an average
of 12 to 18 people without immunity.



PROTECT YOURSELF, YOUR FAMILY AND YOUR COMMUNITY.
GET VACCINATED TODAY.
CONTACT YOUR DOCTOR IMMEDIATELY.

NYC
Health

DOHMH RESPONSE: MMR VACCINE UPTAKE



Source: NYC DOHMH Citywide Immunization Registry, data as of 9/1/2019, run on 9/3/2019

DOHMH RESPONSE: BY NUMBERS

- ~ 560 DOHMH staff deployed
- ~ 104,000 person-hours spent
- 2,279 suspect cases of measles investigated
- >3,200 diagnostic tests performed by DOHMH labs
- Agency spent \$8.4 million to end outbreak
 - Actual cost to community much greater

LESSONS LEARNED

- Decades old public health victories cannot be taken for granted
- More granular surveillance and immunization coverage data key to early identification of susceptible populations
- Leverage community relationships to build new alliances

FUTURE CHALLENGES

- Vaccine hesitancy requires resources for continued education in vulnerable communities
- Ongoing risk of international importation
- Implementation of state law removing religious exemptions and NYC health code changes requiring DOHMH review of all medical exemptions

SPECIAL THANKS TO...

➤ **Division of Disease Control**

Jane R. Zucker M.D., M.Sc., Jennifer B. Rosen, M.D., Martha Iwamoto M.D., Robert J. Arciuolo M.P.H., Marisa Langdon-Embry, M.Sc., Neil M. Vora, M.D., Jennifer L. Rakeman Ph.D., Beth M. Isaac M.P.H., Antonine Jean M.P.H., Mekete Asfaw, Demetre C. Daskalakis M.D., M.P.H

➤ **Office of Emergency, Preparedness & Response**

Beth Maldin Morgenthau, M.P.H.

➤ **Division of Environmental Health**

Simone C. Hawkins

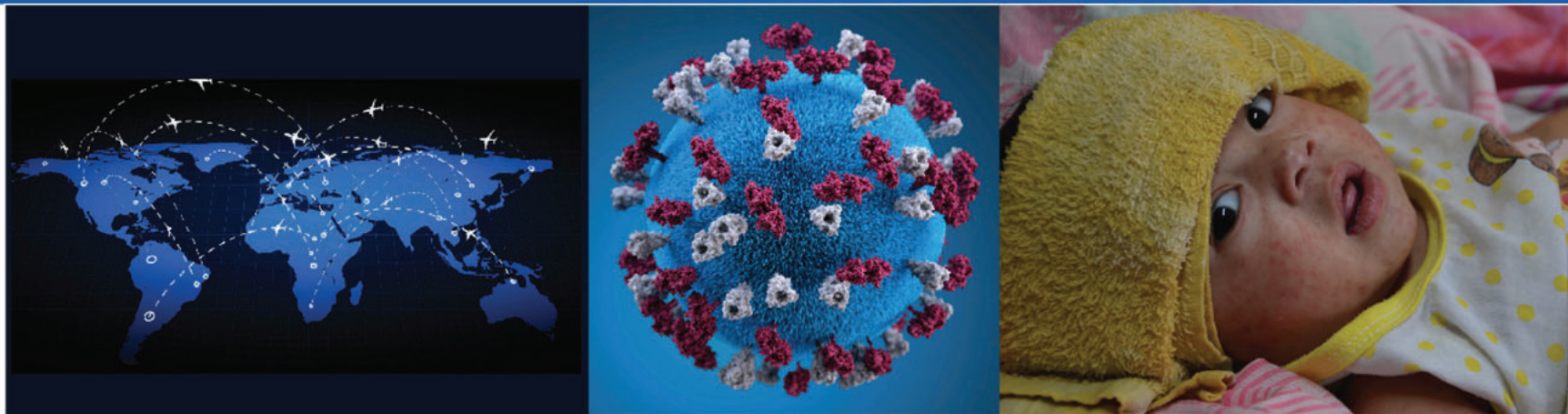
➤ **Office of General Counsel**

Thomas G. Merrill, J.D.

➤ **Office of External Affairs**

Maura Kennelly, M.P.H.

Strengthening Confidence in Vaccines



Amanda Cohn, MD (CAPT, USPHS)

Chief Medical Officer

National Center for Immunization and Respiratory Diseases



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

Vaccine coverage is high in the United States

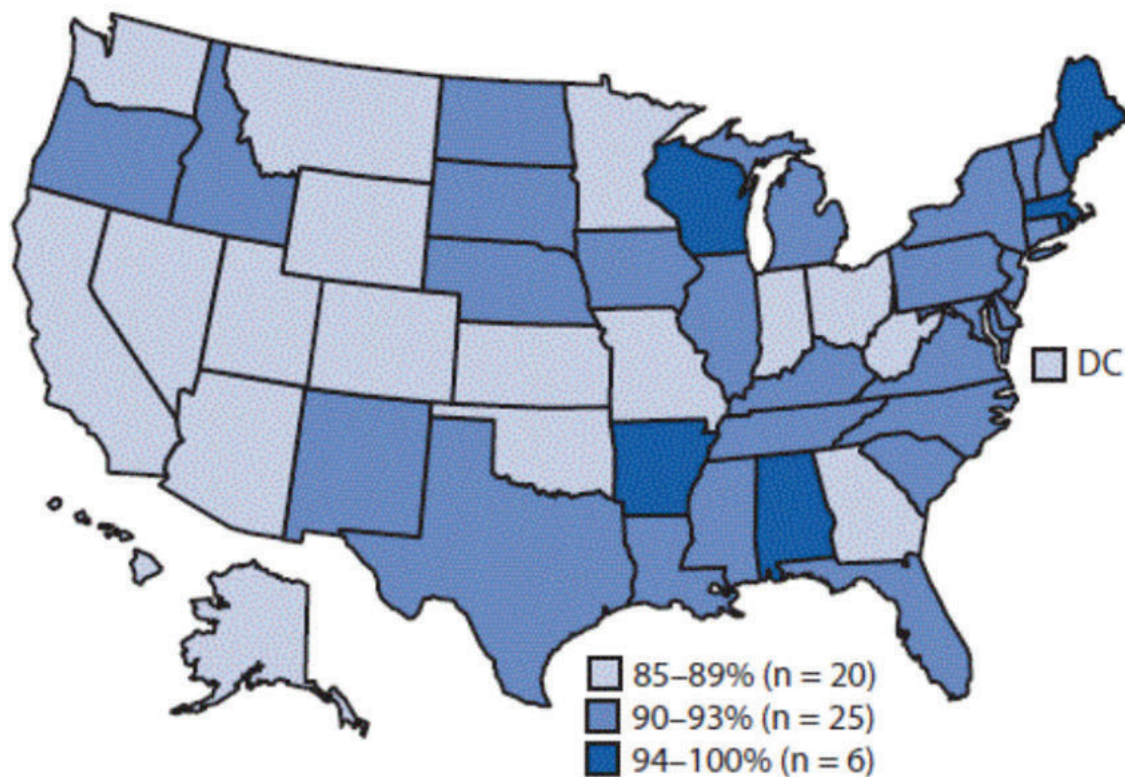
- **Nearly 99% of U.S. children have received some vaccines by the age of 2 years**
- **Over 94% of kindergarteners have received 2 doses of measles, mumps, and rubella vaccine (MMR) and the state-required number of doses of diphtheria, tetanus, and acellular pertussis (DTaP) and varicella vaccines**

Seither et al, MMWR, October 17, 2019

Figure adapted from Gabriele Malaspina, the Noun Project

Some children remain unprotected

≥1 Dose MMR vaccination coverage by 24 months among children born in 2015–2016

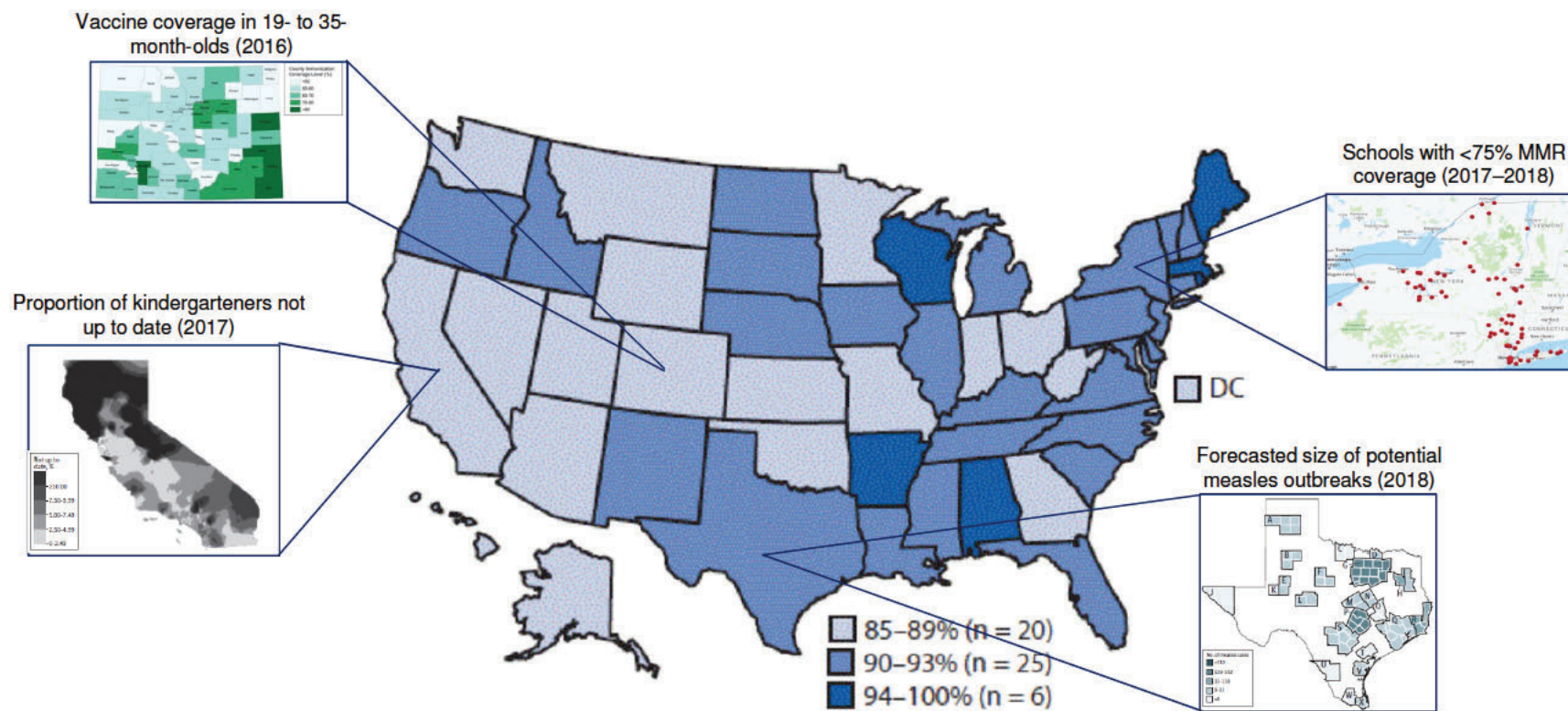


Nationwide coverage: 90.4%

Lower in children who are:

- Uninsured/underinsured
- Reside in rural area
- Live below poverty level

Pockets of low vaccination threaten communities



Source: National Immunization Survey
New York State Student Identification System
Sinclair D, et al. JAMA network open. 2019
Pingali S, JAMA. 2019

Characteristics of Low Vaccination Pockets



- ❑ **Each community is unique**, with distinct factors affecting vaccination:
 - Close-knit
 - Isolation or insularity
 - Access issues
 - Distrust of public authorities
 - Localized misinformation

Myths and misinformation

- ❑ Myths have always been part of the vaccine landscape
- ❑ But **rapid dissemination and sophistication** of misinformation present new challenges
 - Internet access
 - Social media
 - Talk radio and television
- ❑ Misinformation plays a clear role in eroding vaccine confidence and puts our programs at risk



Vaccine misinformation can be tailored for specific communities

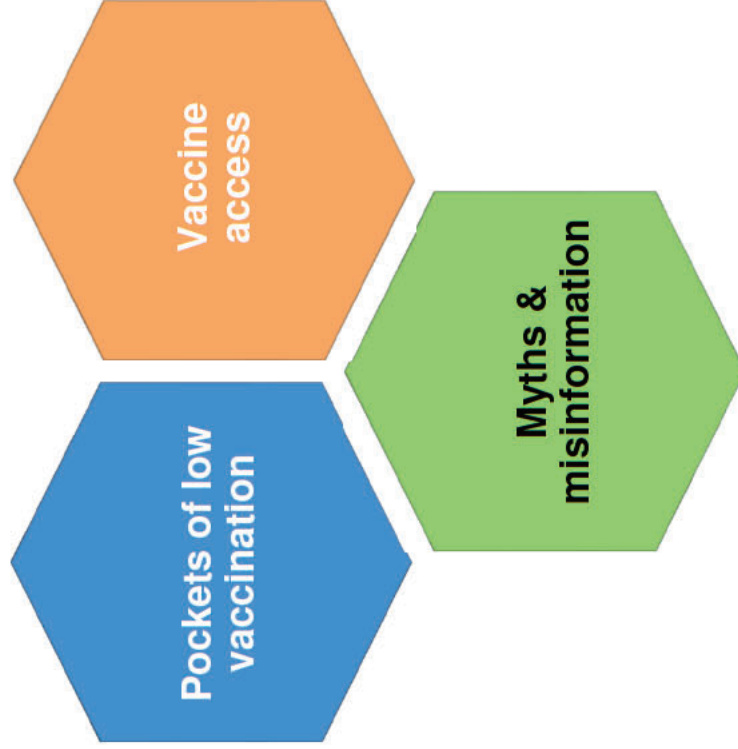


Vaccinate with **Confidence**

Protect communities. Empower families. Stop myths.

CDC's strategic framework for strengthening vaccine confidence and preventing outbreaks of vaccine-preventable diseases in the United States

Lessons learned from recent outbreaks





Vaccinate with **Confidence**

Protect communities. Empower families. Stop myths.

Protect communities

Use every tool available to find and protect communities at risk using tailored, targeted approaches

Empower families

Ensure parents are confident in decision to vaccinate by strengthening provider-parent vaccine conversations

Stop myths

Use local partners and trusted messengers, establish new partnerships to contain the spread of misinformation, and educate critical stakeholders about vaccines



Vaccinate with **Confidence**

Protect communities

- ✓ Leverage immunization data to find and respond to communities at risk
- ✓ Work with trusted local partners to reach at-risk communities before outbreaks
- ✓ Ensure vaccines are available, affordable, and easy to get in every community



Vaccinate with Confidence

Protect communities

- ✓ Leverage immunization data to find and respond to communities at risk
- ✓ Work with trusted local partners to reach at-risk communities before outbreaks
- ✓ Ensure vaccines are available, affordable, and easy to get in every community

Empower families

- ✓ Expand resources for healthcare professionals to help them have effective vaccine conversations with parents
- ✓ Work with partners to start conversations before the first vaccine appointment
- ✓ Help providers foster a culture of immunization in their practices



Vaccinate with **Confidence**

Protect communities

- ✓ Leverage immunization data to find and respond to communities at risk
- ✓ Work with trusted local partners to reach at-risk communities before outbreaks
- ✓ Ensure vaccines are available, affordable, and easy to get in every community

Empower families

- ✓ Expand resources for healthcare professionals to encourage effective vaccine conversations with parents
- ✓ Work with partners to start conversations before the first vaccine appointment
- ✓ Help providers foster a culture of immunization confidence in their practices

Stop myths

- ✓ Work with local partners and trusted messengers to improve confidence in vaccines among key, at-risk groups
- ✓ Work with social media outlets to promote trustworthy vaccine information
- ✓ Provide accurate, accessible information on vaccines to state policy makers
- ✓ Engage state and local health officials to advance effective local responses to misinformation

CDC Progress to Date

- **Assisted states and cities to respond to the worst year for measles since 1992**
- **Developed state and local health department, healthcare provider, and camp toolkits**
- **Worked with key partners to get their perspectives on vaccine hesitancy challenges**
- **Developed strategic framework to strengthen vaccine confidence**
- **Funded new work by key partners to implement immediate efforts**



Picture courtesy of AAP and SELF Magazine.

CDC Priorities



Picture courtesy of AAP and SELF Magazine.

- ❑ Leverage diverse data sources to find and protect communities at risk
- ❑ Expand resources for working with communities
- ❑ Build and foster a culture of immunization in healthcare practices
- ❑ Provide technical assistance to funded partners
- ❑ Strengthen communication strategies
- ❑ Further invest in our vital partners

Partnership is key

- ❑ To truly keep Americans safe, every generation, community, and child needs to be appropriately immunized
- ❑ Together, we can protect our communities, empower families, and stop myths



Picture courtesy of AAP and SELF Magazine.

Thank you



Vaccinate with **Confidence**

Protect communities. Empower families. Stop myths.

For more information, contact CDC

1-800-CDC-INFO (232-4636)

TTY: 1-888-232-6348 www.cdc.gov

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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Upcoming Programs of Interest

March 17, 2020

**Public Health Grand Rounds
Laboratory Response Network**

April 21, 2020

**Public Health Grand Rounds
Predictive Analytics and Public Health**

May 19, 2020

**Public Health Grand Rounds
Smoking Cessation: New Insights and Future Directions**



From: Greene, Danielle (HEALTH)
Sent: Thursday, February 13, 2020 10:53 AM
To: CDC IMS State Coordination Task Force (SCTF) Operations
Subject: Accepted: All State Update Call - COVID-19

From: [Zucker, Howard A \(HEALTH\)](#)
To: [Smith-Hirak, April \(HHS/OASH/DRHA\)](#)
Subject: Re: <no subject>
Date: Wednesday, February 12, 2020 10:28:27 PM

Just busy with coronavirus.

Hope you are feeling better. Kids are vectors!!

Sent from my iPhone

On Feb 12, 2020, at 10:25 PM, Smith-Hirak, April (HHS/OASH/DRHA) <April.Smith-Hirak@hhs.gov> wrote:

ATTENTION: This email came from an external source. Do not open attachments or click on links from unknown senders or unexpected emails.

All is fine. [REDACTED] because little kids are crazy vectors! All ok with you?

On Feb 12, 2020, at 10:01 PM, Zucker, Howard A (HEALTH) <howard.zucker@health.ny.gov> wrote:

Thanks! Will get back to you.
Everything okay?

Sent from my iPhone

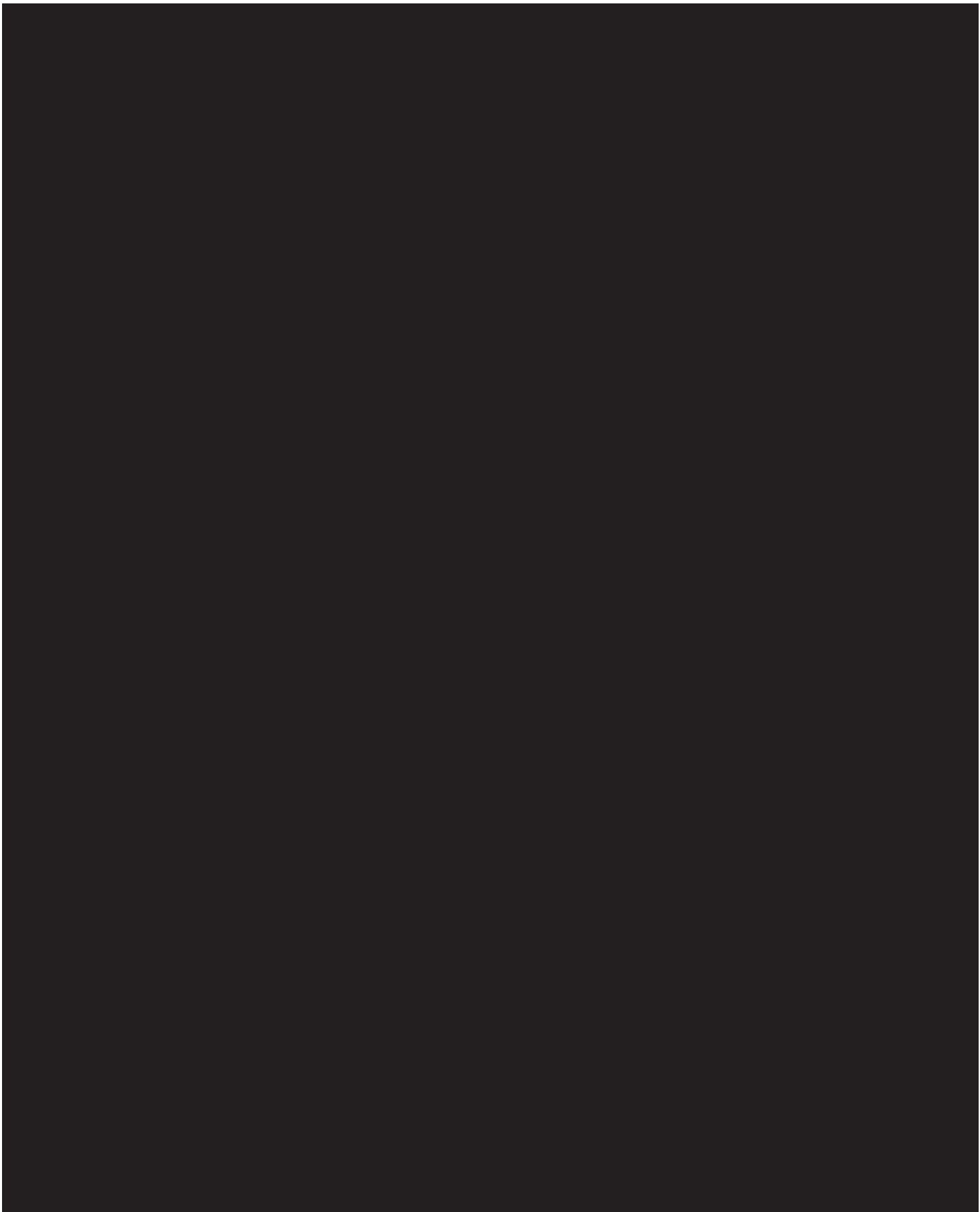
On Feb 12, 2020, at 8:13 PM, Smith-Hirak, April (HHS/OASH/DRHA) <April.Smith-Hirak@hhs.gov> wrote:

ATTENTION: This email came from an external source. Do not open attachments or click on links from unknown senders or unexpected emails.

No worries. If you want to designate a rep to join us, let me know. Otherwise, happy to get answers to any questions you might have.

On Feb 12, 2020, at 4:56 PM, Zucker, Howard A (HEALTH) <howard.zucker@health.ny.gov> wrote:

Thanks for checking. I have to be out of town next Thursday afternoon. Otherwise would have been there. Thanks!



From: CDC IMS State Coordination Task Force (SCTF) Operations
Sent: Monday, February 10, 2020 9:20 AM

To: CDC IMS State Coordination Task Force (SCTF) Lead <eocscftlead@cdc.gov>; EOC Report (CDC) <eocreport@cdc.gov>; Angell, Sonia Y@CDPH <Sonia.Angell@cdph.ca.gov>; Morrow, Scott (CDC smcgov.org) <smorrow@smcgov.org>; Ferrer, Barbara@LACounty <BFerrer@ph.lacounty.gov>; Aragon, Tomas MD, DrPH (CDC sfdph.org) <tomas.aragon@sfdph.org>; Hellerstedt, John (CDC dshs.texas.gov) <John.Hellerstedt@dshs.texas.gov>; Phillip.huang@dallascounty.org <Phillip.huang@dallascounty.org>; vtaneja@TarrantCounty.com <vtaneja@TarrantCounty.com>; Gary.Anthone@nebraska.gov <Gary.Anthone@nebraska.gov>; Wiesman, John (CDC doh.wa.gov) <jmwiesman@doh.wa.gov>; patty.hayes@kingcounty.gov <patty.hayes@kingcounty.gov>; kathleen.toomey@dph.ga.gov <kathleen.toomey@dph.ga.gov>; Zucker, Howard (CDC health.ny.gov) <howard.zucker@health.ny.gov>; Layton, Marci (CDC health.nyc.gov) <mlayton@health.nyc.gov>; Judith.Persichilli@doh.nj.gov <Judith.Persichilli@doh.nj.gov>; Ngozi.Ezike@illinois.gov <Ngozi.Ezike@illinois.gov>; Arwady, Allison AA (CDC cityofchicago.org) <allison.arwady@cityofchicago.org>; bruce.s.anderson@doh.hawaii.gov <bruce.s.anderson@doh.hawaii.gov>; norm.oliver@vdh.virginia.gov <norm.oliver@vdh.virginia.gov>; KhaldunJ@michigan.gov <KhaldunJ@michigan.gov>; Watt, James (CDC cdph.ca.gov) <James.Watt@cdph.ca.gov>; CSallenave@smcgov.org <CSallenave@smcgov.org>; Balter, Sharon (CDC ph.lacounty.gov) <sbalter@ph.lacounty.gov>; juliet.stoltey@sfdph.org <juliet.stoltey@sfdph.org>; Gaul, Linda (CDC dshs.state.tx.us) <linda.gaul@dshs.state.tx.us>; Wendy.Chung@dallascounty.org <Wendy.Chung@dallascounty.org>; Jones, Russ (CDC tarrantcounty.com) <rwjones@tarrantcounty.com>; Safranek, Thomas <NE> (CDC nebraska.gov) <tom.safranek@nebraska.gov>; Lindquist, Scott SL (CDC doh.wa.gov) <scott.lindquist@doh.wa.gov>; Duchin, Jeff (CDC kingcounty.gov) <jeff.duchin@kingcounty.gov>; Drenzek, Cherie (CDC dph.ga.gov) <cherie.drenzek@dph.ga.gov>; Blog, Debra (CDC health.ny.gov) <debra.blog@health.ny.gov>; Tan, Christina CT (CDC doh.nj.gov) <christina.tan@doh.nj.gov>; Layden, Jennifer (CDC illinois.gov) <jennifer.layden@illinois.gov>; sarah.murray@cityofchicago.org <sarah.murray@cityofchicago.org>; sarah.park@doh.hawaii.gov <sarah.park@doh.hawaii.gov>; lilian.peake@vdh.virginia.gov <lilian.peake@vdh.virginia.gov>; Lyoncallos@michigan.gov <Lyoncallos@michigan.gov>; Hawkins, Eric (CDC isdh.in.gov) <ehawkins@isdh.in.gov>; McCormick, Dave (CDC isdh.in.gov) <DMcCormick@isdh.IN.gov>; Susan Fanelli <susan.fanelli@cdph.ca.gov>; tricia.Blocher@cdph.ca.gov <tricia.Blocher@cdph.ca.gov>; Stella Fogleman <sfogleman@ph.lacounty.gov>; jeff.hoogheem@dshs.state.tx.us <jeff.hoogheem@dshs.state.tx.us>; Michelle.Petriatis@dshs.texas.gov <Michelle.Petriatis@dshs.texas.gov>; eric.sergeant@nebraska.gov <eric.sergeant@nebraska.gov>; Halvorson, Clark (CDC doh.wa.gov) <Clark.Halvorson@DOH.WA.GOV>; Minarcine, Scott <Scott.Minarcine@dph.ga.gov>; Primeau, Michael J (HEALTH) <michael.primeau@health.ny.gov>; phillip.hurst@troopers.ny.gov <phillip.hurst@troopers.ny.gov>; bmaldin@health.nyc.gov <bmaldin@health.nyc.gov>; Dana.johnson@doh.nj.gov <Dana.johnson@doh.nj.gov>; Keturah.Tracy@illinois.gov <Keturah.Tracy@illinois.gov>; Winfred.Rawls@illinois.gov <Winfred.Rawls@illinois.gov>; Christopher Shields <Christopher.Shields@cityofchicago.org>; judy.kern@doh.hawaii.gov <judy.kern@doh.hawaii.gov>; tsantos@honolulu.gov <tsantos@honolulu.gov>; bob.mauskapf@vdh.virginia.gov <bob.mauskapf@vdh.virginia.gov>; macqueenm@michigan.gov <macqueenm@michigan.gov>; Scott, Linda (DHHS) <ScottL12@michigan.gov>; mlytle@isdh.in.gov <mlytle@isdh.in.gov>; dutyofficer@cdph.ca.gov <dutyofficer@cdph.ca.gov>; asambol@unmc.edu <asambol@unmc.edu>; brian.hiatt@doh.wa.gov <brian.hiatt@doh.wa.gov>; Harjinder.Ghuman@dph.ga.gov <Harjinder.Ghuman@dph.ga.gov>; kirsten.st.george@health.ny.gov

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Subject: CDC Returning Traveler Discussion for F11 Jurisdictions

When: Wednesday, February 12, 2020 3:00 PM-4:00 PM.

Where: Bridgeline: 1(888)455-7719 Passcode: [REDACTED] or Bldg. 21 3rd Floor 3025B

CDC Returning Traveler Discussion for F11 Jurisdictions

CDC's 2019 Novel Coronavirus (2019-nCoV) response team will host a call from 3 p.m. to 4 p.m. EST for the duration of this week, to discuss plans for returning travelers **within the eleven funneling jurisdictions**, status reports and concerns. Feel free to include your state epidemiologist, preparedness director, state/city emergency management official, and other core team members.

Bridgeline: 1(888)455-7719

Passcode: [REDACTED]

From: [Barbara Knappmeyer](#)
To: [King, Brian a. \(CDC/DDNID/NCCDPHP/OSH\)](#); [Layden, Jennifer E.](#); [Zucker, Howard A \(HEALTH\)](#); [Dawkins, Edna \(CDC/DDNID/NCCDPHP/OSH\) \(CTR\)](#); [Silvia, Jacqueline S \(HEALTH\)](#); [Alexandra Loukas](#); [Sonya Dougal](#); [Sutton, Barbara \(HEALTH\)](#); [Susan Schulz](#)
Subject: Vaping agendas
Date: Wednesday, February 12, 2020 2:00:39 PM
Attachments: [Vaping EveningPanel Agenda NYAS.pdf](#)
[Vaping Conference Agenda NYAS.pdf](#)
[4 2-3 20 Vaping - Flyer SS2.pdf](#)

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Dear all,

Thank you for taking the time for the phone call today and for your valuable suggestions.

Please find attached the agenda and a flyer for your reference. It is also [available online for the day](#) and the [evening events](#). We will be following up shortly with more marketing materials and schedule a pre-panel discussion phone call with all panelist in Session 1.

Please don't hesitate to reach out with any questions.

And again, thank you so much for your help with shaping the agenda for these events.

We are really excited for the program and look forward to seeing you all soon.

Kind regards,

Barbara

Barbara Knappmeyer, PhD

Program Manager, Life Sciences

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The Youth Vaping Epidemic: From Science to Public Policy
April 3, 2020

Scientific Organizing Committee.

- **Brian King**, PhD, Centers for Disease Control and Prevention
- **Jennifer Layden**, MD, Illinois Department of Public Health
- **Alexandra Loukas**, PhD, The University of Texas at Austin
- **Howard Zucker**, MD, JD, Commissioner, New York State Department of Health
- **Sonya Dougal**, PhD, The New York Academy of Sciences
- **Barbara Knappmeyer**, PhD, The New York Academy of Sciences

Symposium Synopsis.

Teenagers are vaping in record numbers, while vaping associated lung injuries and deaths continue to rise. This youth vaping epidemic highlights the urgent need to understand the science of nicotine addiction, in particular with regard to the developing brain, and the potential long-term health effects of other compounds found in vapes. This symposium will convene experts from academic, clinical and public policy communities to discuss new targets for prevention with a focus on emerging science to develop evidence-based policy recommendations.

Proposed Conference Program.

- 8:30 – 9:00 am Registration & Breakfast
- 9:00 - 9:15 am Opening Remarks:
Sonya Dougal, PhD, The New York Academy of Sciences
- 9:15 - 9:45 am Overview:
Brian King, PhD, Centers for Disease Control and Prevention

Session 1: Neuroscience of Nicotine Addiction and Health Effects of Vaping
Chair: Alexandra Loukas, PhD

- 09:45 -10:15 am Addictive Effect of Nicotine, Long-term Effects on the Brain
Frances Leslie, PhD, University of California, Irvine
- 10:15 -10:45 am Break
- 10:45-11:30 am Panel Discussion: Factors Driving the Youth Vaping Epidemic
- **Bonnie Halpern-Felsher, PhD, Stanford University**
 - **Rachel Grana Mayne, PhD, National Cancer Institute**
 - **Suchitra Krishnan-Sarin, PhD, Yale School of Medicine**

11:30-12:00 pm EVALI and Lung Disease
Jennifer Layden, MD, Illinois Department of Public Health

12:00-12:30 pm Health Risks of Electronic Nicotine Delivering Systems
Nancy Rigotti, MD, Harvard Medical School

12:30 – 2:00 pm Networking Lunch

Session 2: Public Policy for Prevention - Chair: Brian King

2:00 – 2:30 pm Policy Overview
Howard Zucker, MD, JD, Commissioner, New York State Department of Health

2:30 – 3:00 pm Regulatory Issues
David Kessler, MD, University of California, San Francisco

3:00 – 3:30 pm Networking Coffee Break

3:30 – 4:00 pm School Policy – Challenges & Recommendations
Steve Kelder, PhD, University of Texas at Austin, CATCH

4:00 – 4:30 pm Different Approaches in Different States
Matthew Myers, JD, Campaign for Tobacco-Free Kids

4:30 – 5:00 pm Patterns and Predictors of Youth Vaping
Donna Vallone, PhD, The Truth Initiative, New York University

5:00 – 5:15 pm Closing Remarks

5:15 – 6:00 pm Networking Reception

6:00 pm Adjourn



Vaping: Fact versus Fiction (April 2, 2020)

Scientific Organizing Committee.

- **Brian King**, PhD, Centers for Disease Control and Prevention
- **Jennifer Layden**, MD, Illinois Department of Public Health
- **Alexandra Loukas**, PhD, The University of Texas at Austin
- **Howard Zucker**, MD, JD, Commissioner, New York State Department of Health
- **Sonya Dougal**, PhD, The New York Academy of Sciences
- **Barbara Knappmeyer**, PhD, The New York Academy of Sciences

Symposium Synopsis.

Teenagers are vaping in record numbers, while vaping-associated lung injuries and deaths continue to rise. This evening panel will help separate fact from fiction about vaping, and discuss potential policy measures to help protect public health. Questions to be addressed include -- is vaping addictive? What are the health consequences of vaping? Are vaping bans the solution to stemming the youth epidemic? Panelists bring together perspectives ranging from public health policy, advocacy, and parenting, to science and medicine.

Proposed Conference Program.

6:30 – 6:40 pm Welcome Remarks

6:40 – 7:30 pm Panel Discussion

Moderator: TBD

Panelists:

- Meredith Berkman (Parents Against Vaping e-Cigarettes)
- Caleb Mintz (Highschool Junior, Teen Anti-Vaping Activist)
- Bonnie Halpern-Felsher, MD (Stanford University)
- Howard Zucker, MD, JD (Commissioner, New York State Department of Health)
- Steve Kelder, PhD (University of Texas at Austin, CATCH)

7:30 - 8:15 pm Question and Answers

8:15 - 8:30 pm Closing Remarks

8:30 pm Adjourn

From: [Centers for Disease Control and Prevention](#)
To: [Dreslin, Sally R \(HEALTH\)](#)
Subject: CDC EPIC exchange: REMS TA Webinar & CNCS Partner Exclusive
Date: Tuesday, February 11, 2020 3:31:15 PM

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February 11, 2020

EPIC Exchange



Don't keep this great resource to yourself! Please share it with your colleagues and networks. If you

would like more information on Emergency Preparedness and Response, visit [CDC's Emergency Preparedness & Response](#) website.

2019 Novel Coronavirus

The Centers for Disease Control and Prevention (CDC) is closely monitoring an outbreak of respiratory illness caused by a novel (new) coronavirus first identified in Wuhan, Hubei Province, China. CDC features a [FAQ webpage](#) that can answer many questions you may have and a [microsite](#) that contains updated information and guidance as they become available.

EPIC Webinar

CDC EPIC Webinar February 19 at 1 p.m. ET: Fundamentals of Emergency Planning for Schools with REMS TA Center

Girl wearing pink sparkly back pack walking hand-in-hand with her father



Emergency planning is critical for all, but especially for at-risk populations, as they depend on others planning for them and helping to keep them safe. Schools are a primary example; our youth spend most of their time during the year within the custody of schools and school personnel. Developing a high-quality school emergency operations plan is critical to keep youth safe. These plans should account for all settings and all times and include all possible threats and hazards. They also need to account for access and functional needs for the whole school community. Such plans should be supported by leadership, built through a collaborative process, and customized to the building level.

The U.S. Department of Education's Office of Safe and Supportive Schools administers the Readiness and Emergency Management for Schools Technical Assistance (REMS TA) Center—the national TA center serving public and nonpublic education agencies with their comprehensive school preparedness efforts (including school safety, security, and emergency management). Please join us on **February 19 at 1 p.m. ET** for a webinar with the REMS TA Center's Project Director and Deputy Project Director, and the U.S. Department of Education's project administrator. They will share information on the fundamentals of emergency planning for schools and resources available to support comprehensive planning efforts.

Learning Opportunities and Resources

[NPHIC Outbreak Communications Guide](#)

When a disease outbreak occurs, public health communicators need to be prepared. The National Public Health Information Coalition (NPHIC) developed this Outbreak Communications Guide as part of its cooperative agreement with CDC's National Center for Immunization and Respiratory Diseases. This guide may not cover every aspect of an outbreak; however, it is a good place to start. The steps outlined will help guide your actions before, during, and after an outbreak.

[Crisis & Emergency Risk Communication Webinars](#)

Crisis and Emergency Risk Communication (CERC) training can help responders and public health professionals prepare to communicate in an emergency. CERC trainings are based on lessons learned during public health emergencies and evidence-based practices from the fields of risk and crisis communication, and psychology. **CE accreditation for CERC webinar offerings will expire May 1, 2020**, and will not be renewed. CERC [web-based training](#) will continue to offer CEUs and CHES Category I continuing education contact hours.

EPIC Exclusive: Corporation for National Community Service



What is the mission of your organization?

The Corporation for National and Community Service (CNCS) is a federal agency that engages millions of Americans in service through its AmeriCorps and Senior Corps programs and leads the nation's volunteering and service efforts. CNCS's mission is to improve lives, strengthen communities, and foster civic engagement through service and volunteering.

What is the role of your organization in a public health emergency?

Our Disaster Services Unit leads and coordinates National Service support between our programs, FEMA, state service commissions, and other partners and stakeholders during disasters and emergencies. While CNCS is not officially tasked with public health emergencies, through our National Service programs, our members and volunteers may assist with public health information distribution and support services at the local, state, and national level. During the Flint, Michigan Water Crisis, National Service members and volunteers distributed water, assisted with water filtration supply access and installation, and supported information distribution to all parts of the community.

How do you plan for emergencies?

We have a broad approach to planning for emergencies:

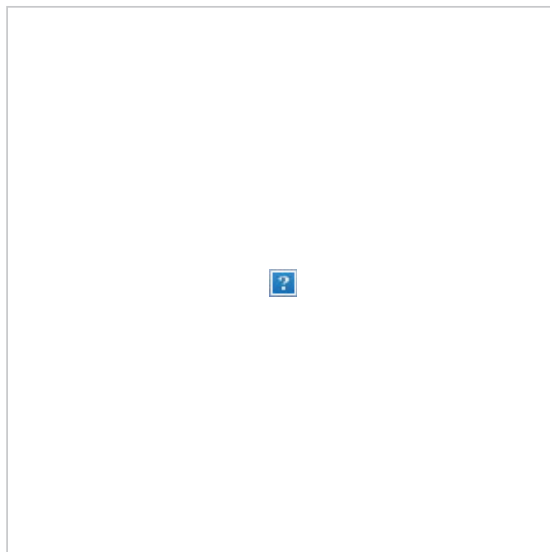
- We have an internal Disaster Services Framework for our agency that outlines the roles and responsibilities for our programs and departments during times of disaster.
- After every disaster response operation, we hold after-action meetings to identify lessons learned, inform our future planning, and identify and develop “improvement projects” to enhance our future operations.
- We participate in national level exercises and simulations with our federal and state partners.
- We develop and deliver training to our network and partners on disaster response, recovery, and preparedness. We also participate in National VOAD and other conferences to share information about National Service support in times of disaster.

What is one experience or lesson-learned that you have from an emergency response?

As an agency, we have had several responses that taught us a great deal, but perhaps the biggest watershed moment of learning for us was Hurricane Sandy. Responding to this storm was unique in many ways; it challenged our AmeriCorps Disaster Response Teams (A-DRTs), who were used to rural response, with heightened planning and logistics necessary for an urban response. We learned that in order to be successful and efficient, our A-DRTs needed to work more cohesively and share common operating standards. This response pushed us to adapt the Incident Command System for our operations, create common training for all our A-DRTs, and reinvigorate our staff to provide on-the-ground support to our teams through our CNCS Disaster Cadre program. As a result, the unprecedented 2017 hurricane season found our Disaster Services Unit, a team of three people at the time, capably managing over 500 A-DRT personnel a day for many months in four locations (TX, FL, PR, USVI) at the highest level of operations complexity and magnitude.

What is one piece of advice that you would give to other EPIC partners?

Commit to the planning cycle: make the plan, exercise the plan, learn from real-world implementation, and revise the plan. The time and energy we devoted to planning after Hurricane Sandy was vital to our overwhelmingly successful 2017 hurricane responses.



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Questions?

[Contact CDC-INFO](#)

800-CDC-INFO (800-232-4636) TTY: 888-232-6348



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From: [LeBlanc, Tanya \(CDC/DDPHSIS/CPR/DSLRL\)](#)
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Cc: [St. Pierre, Jeanette \(CDC/DDID/NCIRD/DVD\)](#)
Subject: February 2020 Public Health Grand Rounds Dress Rehearsal - Topic Measles
Date: Tuesday, February 11, 2020 10:19:53 AM
Attachments: [image001.png](#)
[measles slides-february-11-2020.pdf](#)

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Dear All, Please see the attached PDF file containing the entire session for Public Health Grand Rounds next week. Thanks again for your collegial collaboration!

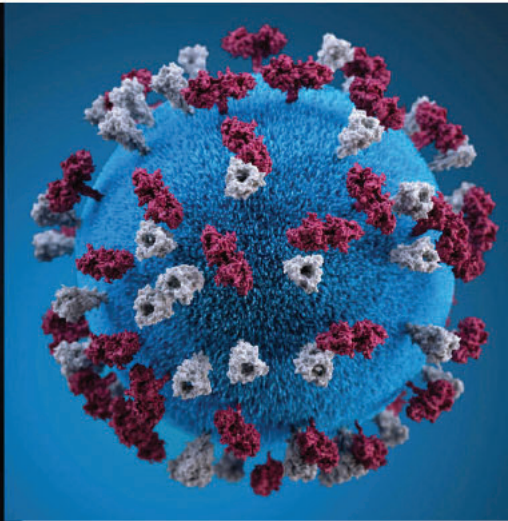
Let me know if any last minute changes should be made. This is the last look!

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CDC PUBLIC HEALTH GRAND ROUNDS

Measles – Maintaining Disease Elimination and Enhancing Vaccine Confidence



Tuesday, February 18, 2020
1:00 p.m. – 2:00 p.m. (ET)

Continuing Education Information

Continuing education: www.cdc.gov/getce

- After creating a TCEO account, click the “Search Courses” tab on the left and use “Public Health Grand Rounds” as a keyword search.
- All PHGR sessions eligible for CE should display, select the link for today’s session and then Continue button. [Course Access Code is PHGR10](#).
- CE expires **March 23, 2020** for live and **February 20, 2022** for Web On Demand courses.
- Issues regarding CE and CDC Grand Rounds, email: tceo@cdc.gov

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Public Health Grand Rounds Resources

Send comments or questions to:
grandrounds@cdc.gov

**[youtube.com/user/
CDCStreamingHealth](https://youtube.com/user/CDCStreamingHealth)**

**Access full
PHGR sessions &
Beyond the Data**

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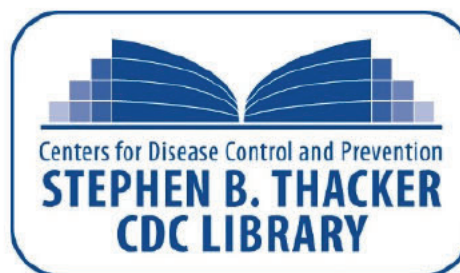
Additional Resources

Beyond The Data

**“Take home” messages in a
short podcast at:
cdc.gov/grand-rounds**



science**clips**
CDC



**Scientific publications about
this topic at:
cdc.gov/library/sciclips**

Email grandrounds@cdc.gov with any questions or for help locating the additional resources

Today's Speakers and Contributors



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Howard Zucker, MD, JD
New York State Health Commissioner



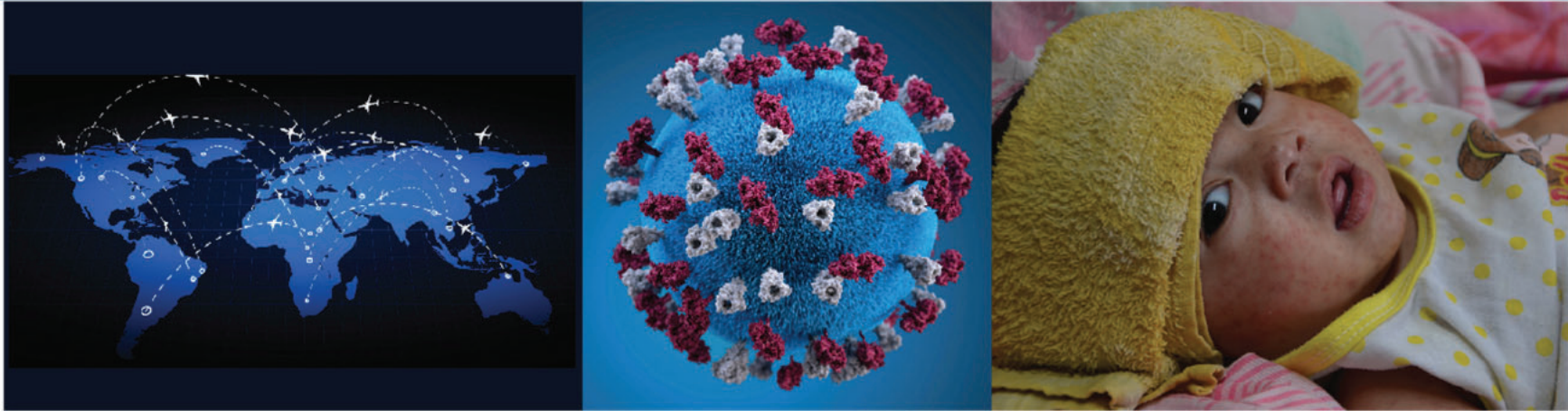
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Measles in the United States



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U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

Characteristics of Measles

- Most contagious of the vaccine-preventable diseases ($R_0 = 12-16$)
- Acute, febrile rash viral illness
 - High fever, cough, coryza, conjunctivitis
- Incubation period: 10–14 days
- Infectious period: 4 days before & through 4 days after rash onset



Measles complications



- Diarrhea (8%)
- Otitis media (7%–9%)
- Pneumonia (1%–6%)
- Hospitalized (10%–25%)
- Encephalitis (1 per 1,000)
- Death (1–3 per 1,000)
- Subacute sclerosing panencephalitis (1 per 5,000–10,000)

Measles, Mumps, Rubella (MMR) Vaccine

➤ Vaccine effectiveness (VE)

- 1 dose of MMR: ~93%
- 2 doses of MMR: ~97%

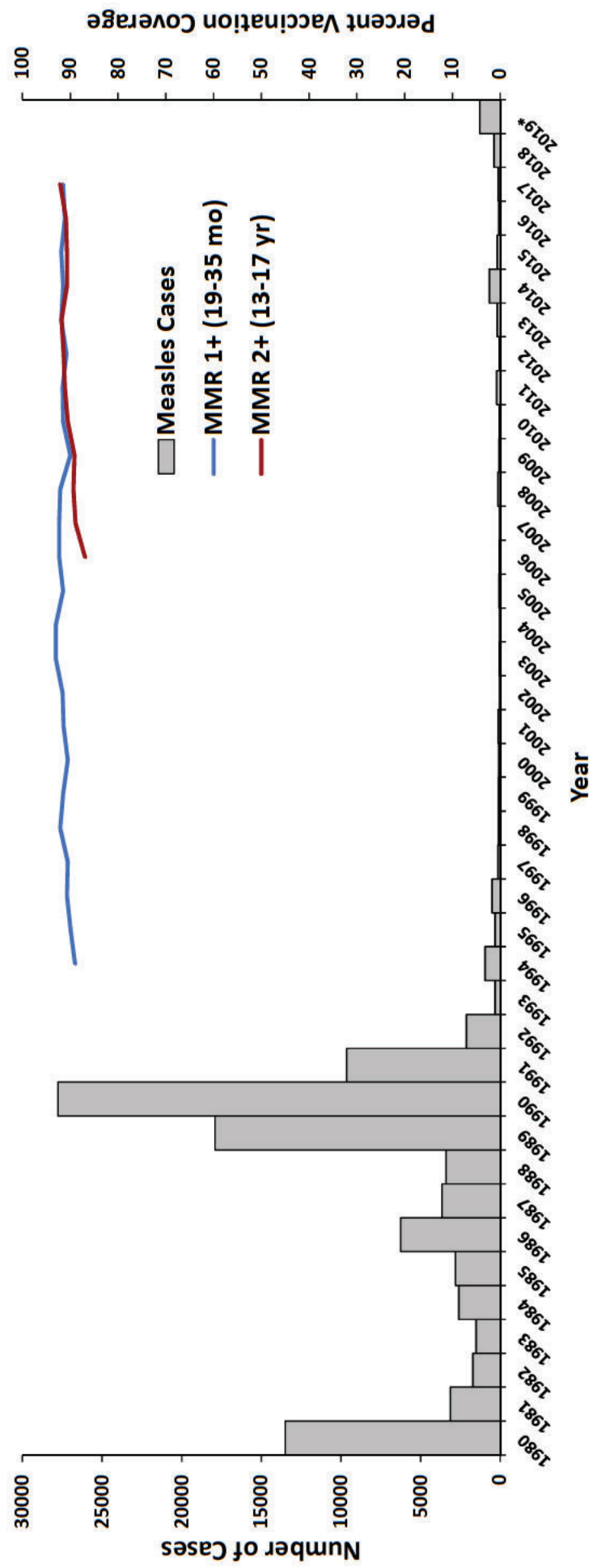
➤ Excellent safety profile over past 50 years

- Common side effects are usually mild and resolve spontaneously
- Serious adverse events are extremely rare

Measles, Mumps, Rubella (MMR) Vaccine Recommendations

- **Children and adolescents need TWO doses of MMR**
 - First dose at 12 to 15 months of age, and second dose at 4 to 6 years of age
- **Most adults need only ONE dose of MMR**
 - Two doses are recommended for adults at HIGH RISK for exposure, including healthcare personnel, post-high school students, international travelers
- **Infants 6–11 months of age traveling internationally need ONE dose**

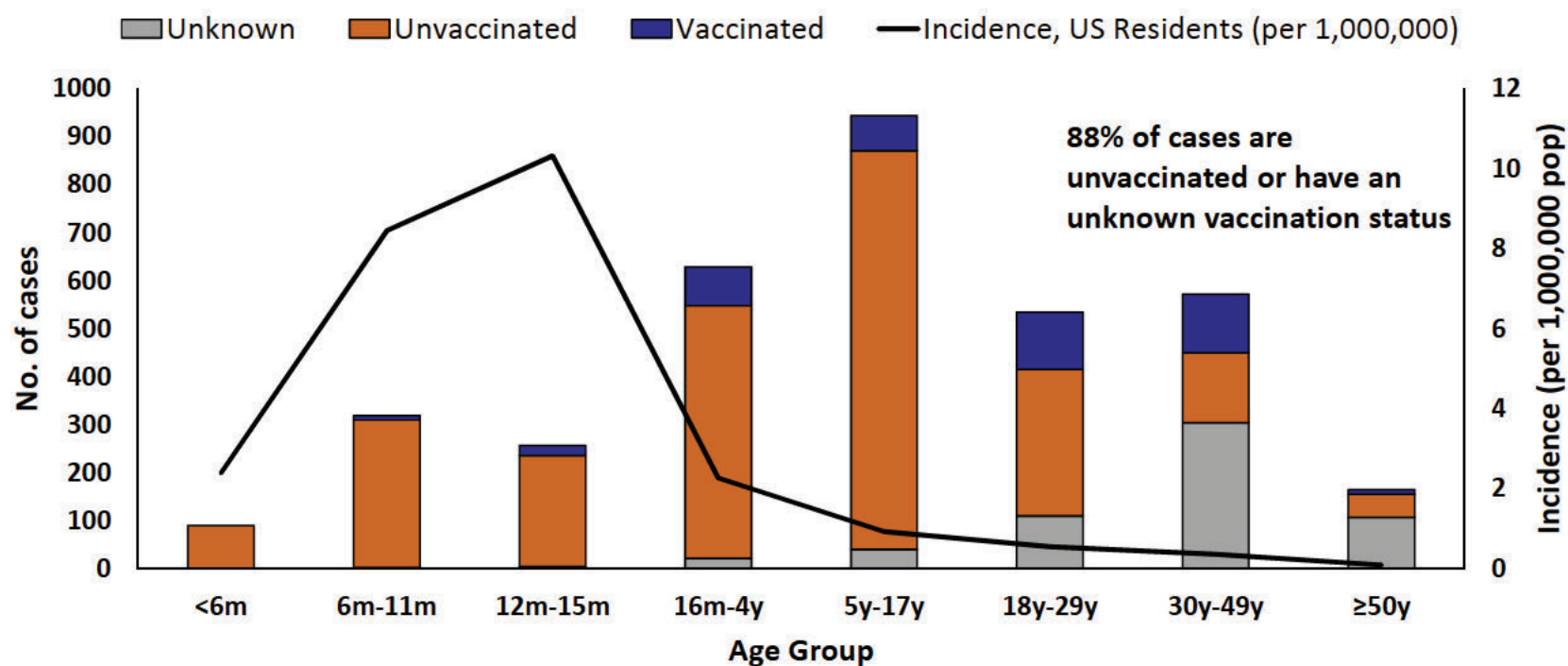
High MMR coverage in the United States led to elimination of measles in 2000



*Source: National Notifiable Diseases Surveillance System (passive surveillance); data as of January 31, 2020; National Immunization Survey, CDC

Most measles cases in the United States are among unvaccinated people

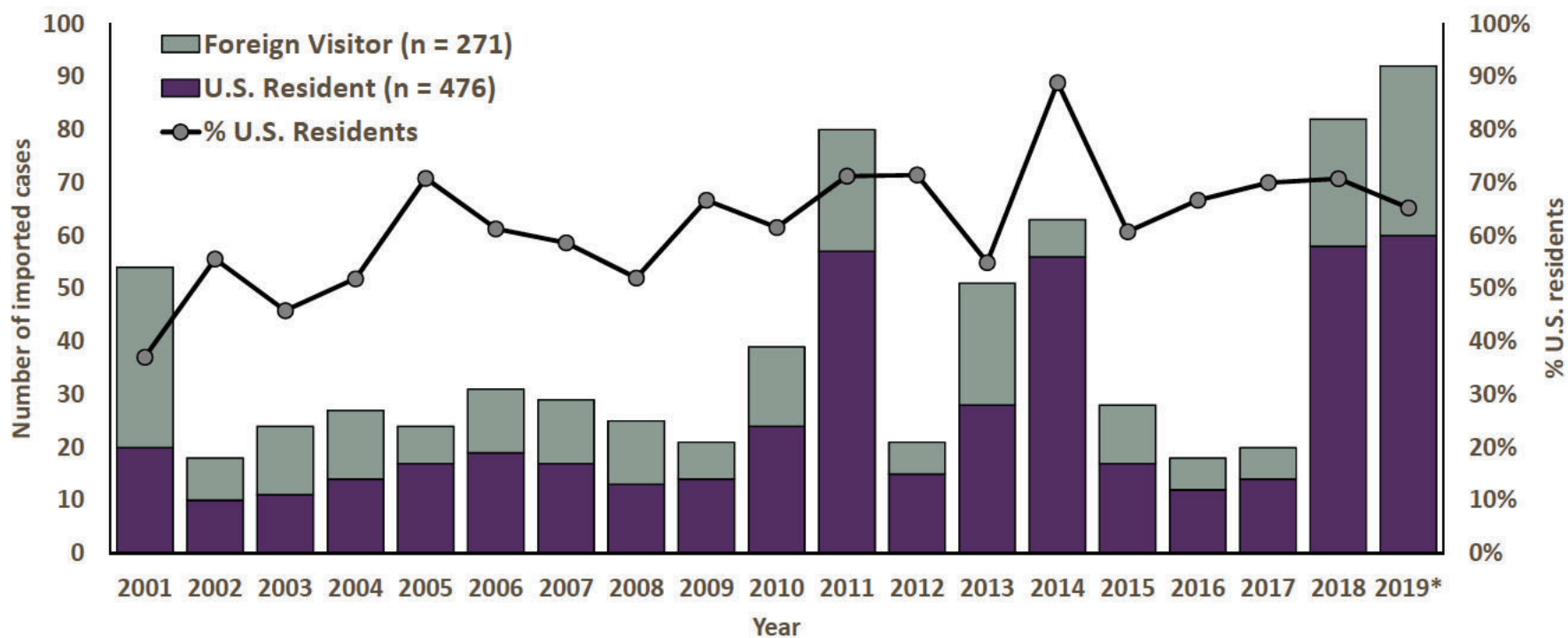
Measles cases by vaccination status and incidence rate, United States, 2001–2019 (N=3,881)



*Source: National Notifiable Diseases Surveillance System (passive surveillance); data as of January 31, 2020

Majority of measles importations are among U.S residents who traveled abroad

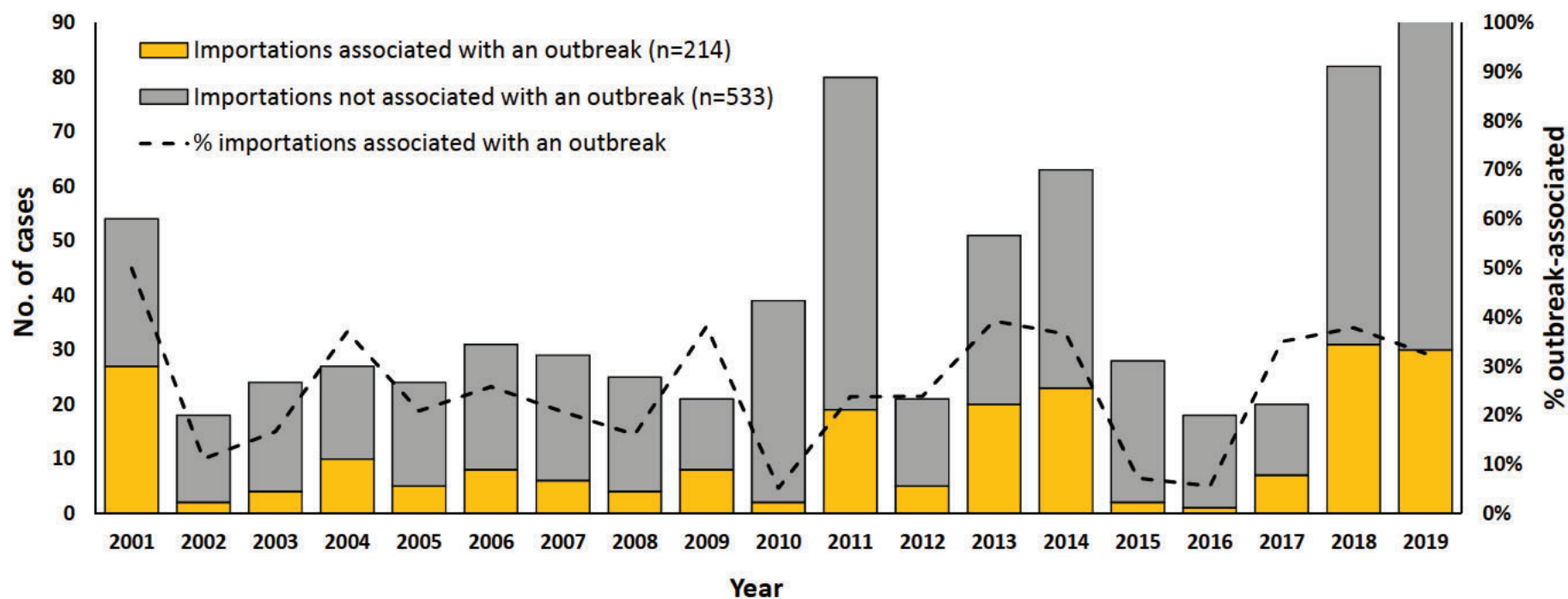
Measles cases by residential status, United States, 2001–2019 (N=747)



*Source: National Notifiable Diseases Surveillance System (passive surveillance); data as of January 31, 2020

Most U.S. importations are NOT associated with outbreaks

Outbreak vs. not outbreak-associated international importations, U.S., 2001–2019 (N=747)

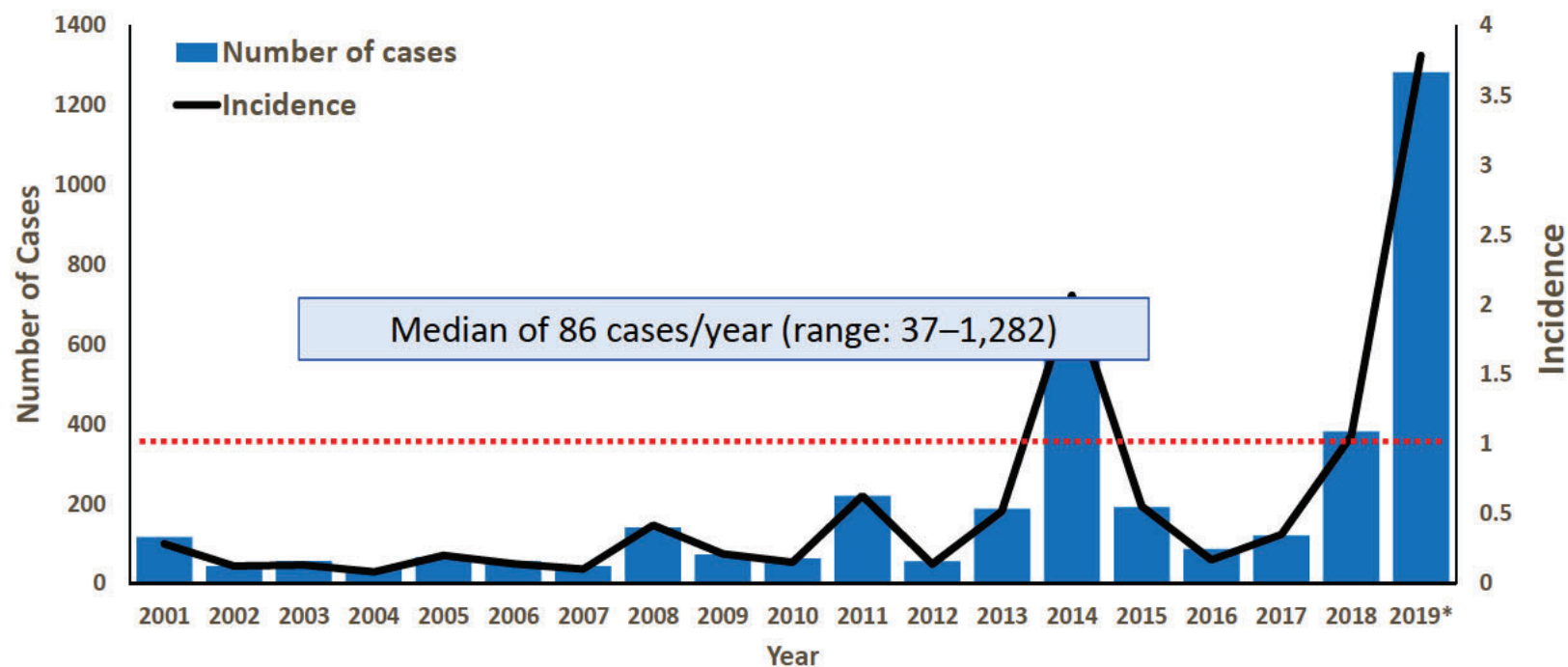


Median 28 importations per year, range 18–92

*Source: National Notifiable Diseases Surveillance System (passive surveillance); data as of January 31, 2020

The United States has seen a recent increase in measles

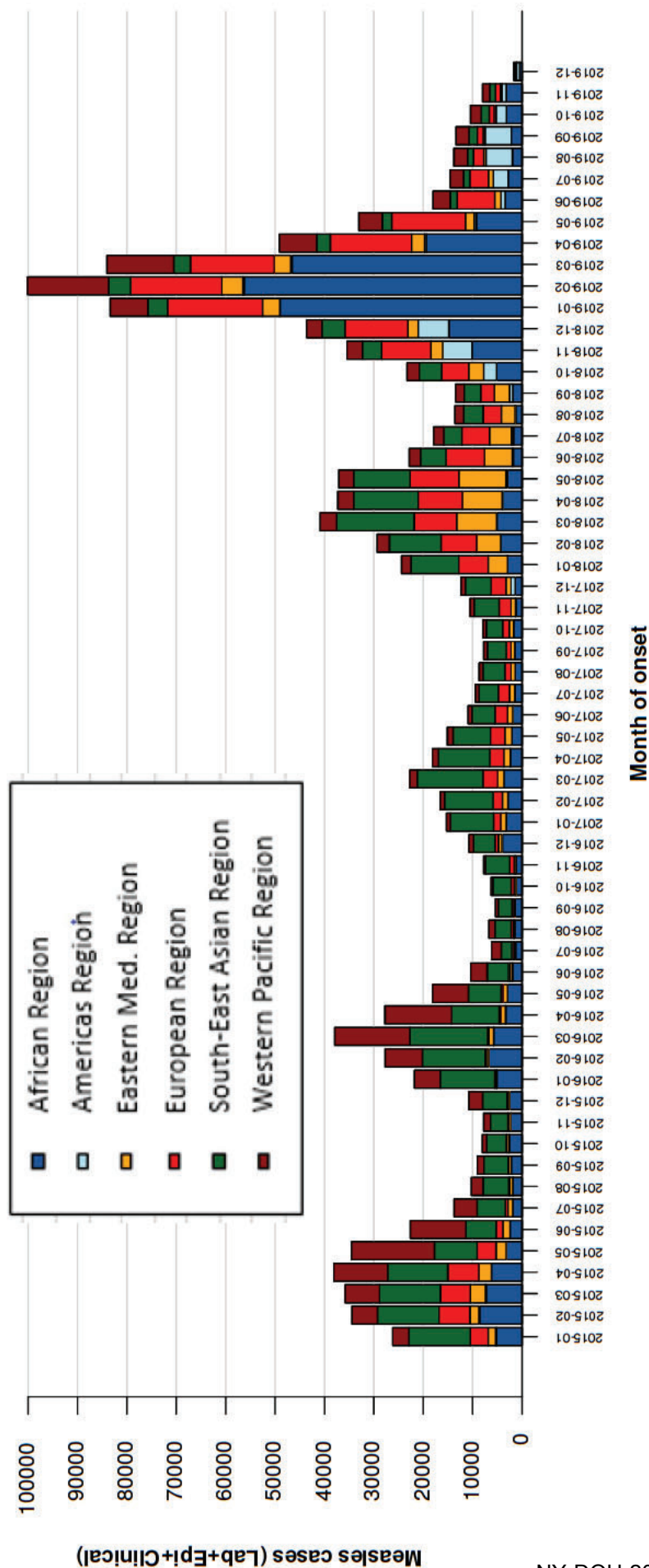
Number of reported measles cases, United States, 2001–2019* (N=3,881)



Median of 86 cases/year (range: 37–1,282)

*Source: National Notifiable Diseases Surveillance System (passive surveillance); data as of January 31, 2020

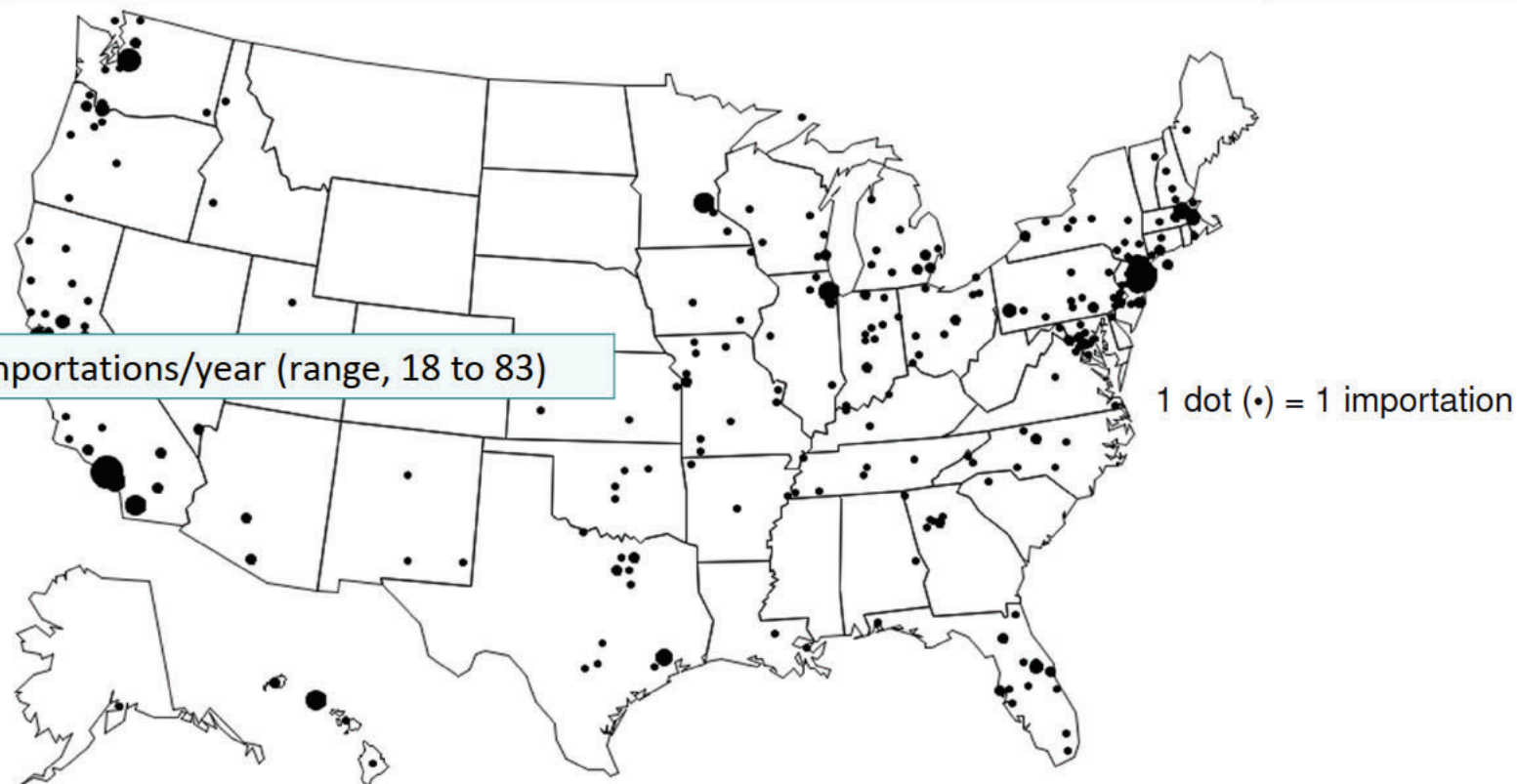
Global measles cases tripled in 2019



*Source: WHO:

https://www.who.int/immunization/monitoring_surveillance_burden/vpd/surveillance_type/active/measles_monthlydata/en/

Wide geographic distribution of measles importations, United States, 2001–2019 (N=747)

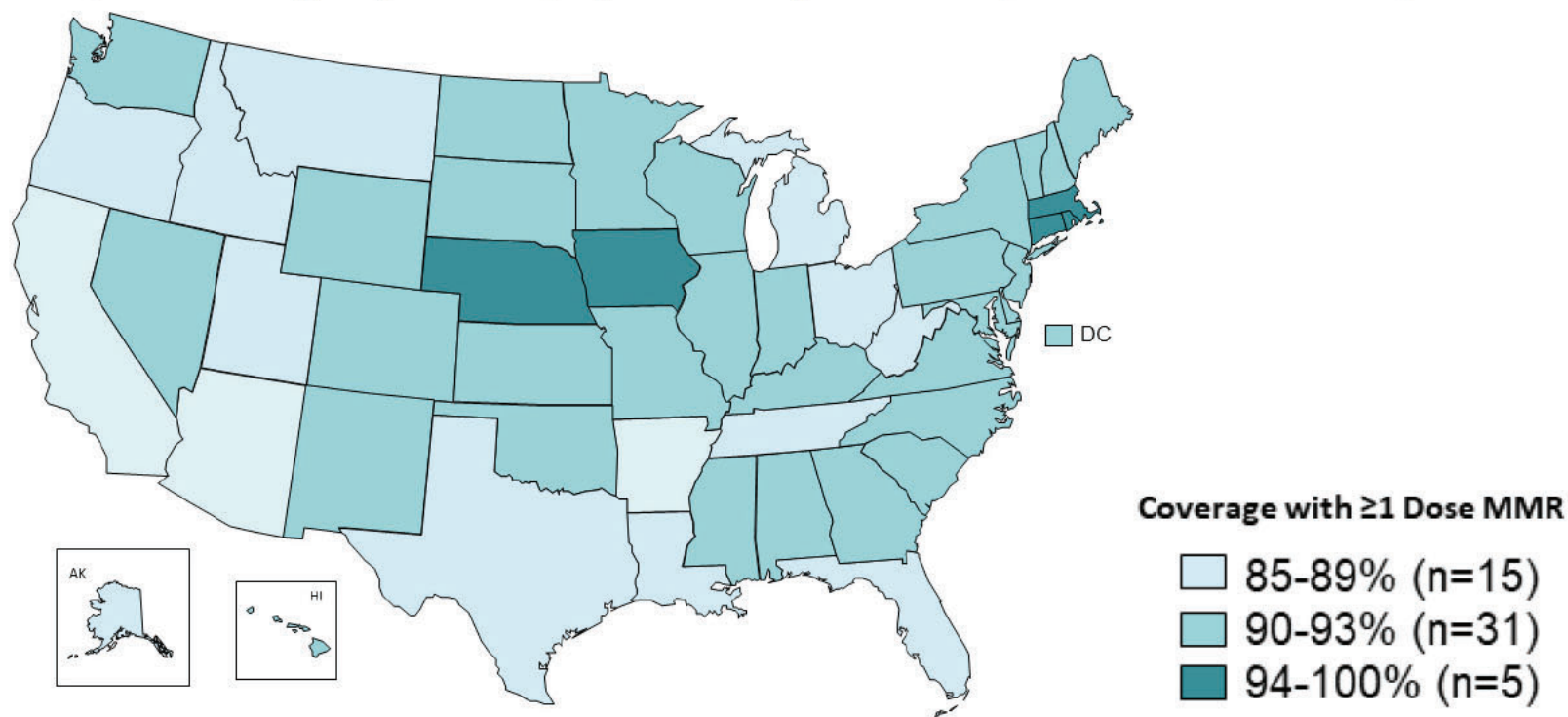


Median of 28 importations/year (range, 18 to 83)

***Source: National Notifiable Diseases Surveillance System (passive surveillance); data as of January 31, 2020**

Variability in state and local MMR vaccine coverage can result in populations at risk for measles outbreaks

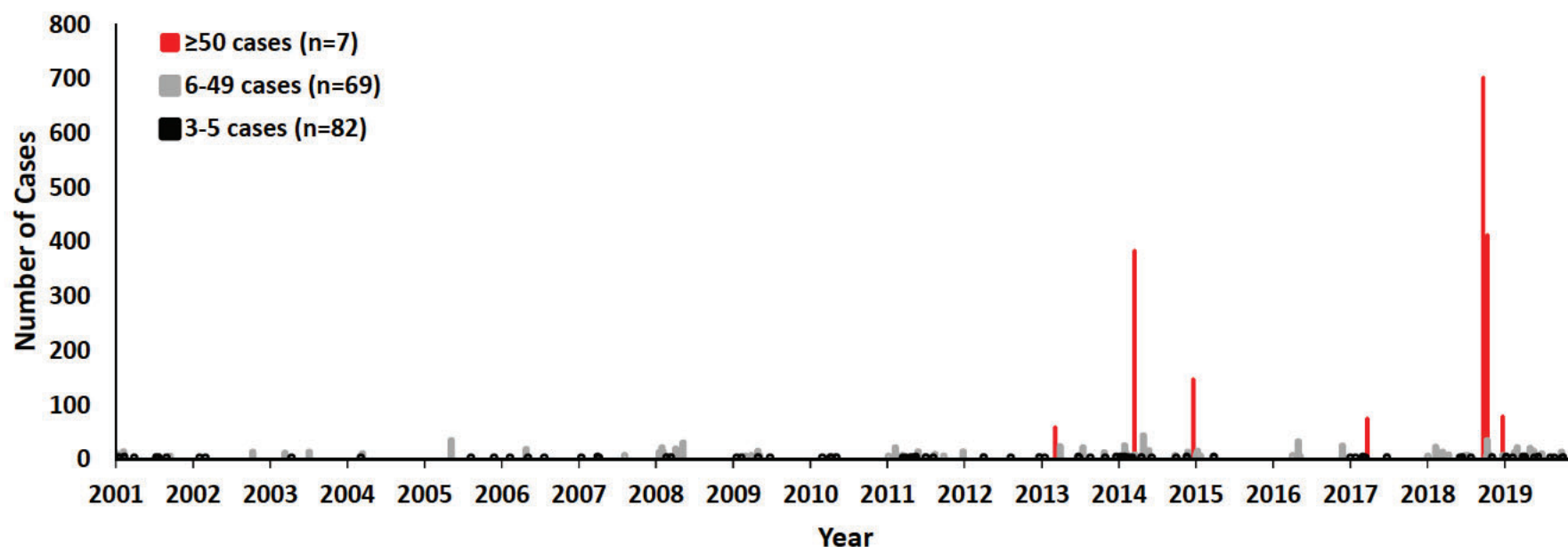
≥1 Dose MMR Vaccination Coverage by 24 Months, NIS-Child, U.S. 2013 to 2014 Combined Birth Years



Source: National Immunization Survey

**Most U.S. measles outbreaks have been of limited size and duration.
Larger and more sustained outbreaks have been observed more recently**

Number and size of measles outbreaks, U.S., 2001–2019 (N=158 outbreaks)



Number of outbreaks: Median of 4 outbreaks/year (range, 2 to 25)

Size: Median of 5 cases/outbreak (range, 3 to 702)

Duration: Median 23 days/outbreak (range, 3 to 322)

***Outbreaks are defined as ≥3 cases linked in time and place**

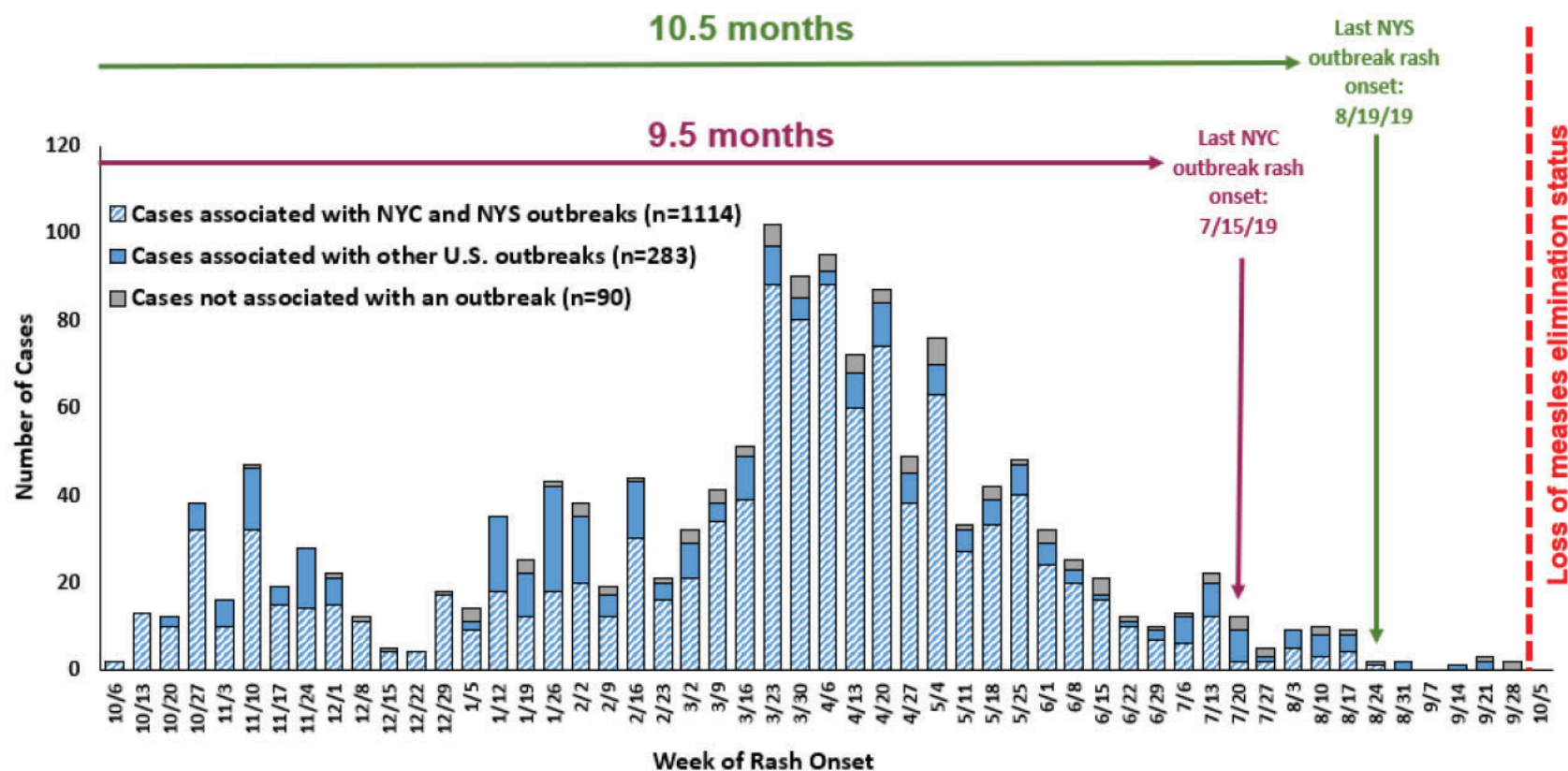
Source: National Notifiable Diseases Surveillance System (passive surveillance); data as of January 31, 2020

Largest measles outbreaks occurred within undervaccinated, close-knit and closed communities

Year	State	Source (genotype)	Community	Cases	Duration (months)
2013	NYC	UK (D8)	Orthodox Jewish	59	2.9
2014	OH	Philippines (D9)	Amish	383	4
2017	MN	Unknown (B3)	Somali	75	3.8
2014/2015	CA + 7 states	Unknown (B3)	Various	147	2.3
2018/2019	WA + 2 states	Ukraine (D8)	Ukrainian Russian Moldovan	78	2.5
2018/2019	NY, NYC + 4 states	Israel/Ukraine (D8)	Orthodox Jewish	1,114	10

Measles outbreaks in New York threatened measles elimination status in the United States

Number of reported measles cases (N=1,518), by week of rash onset, United States, September 30, 2018–December 31, 2019

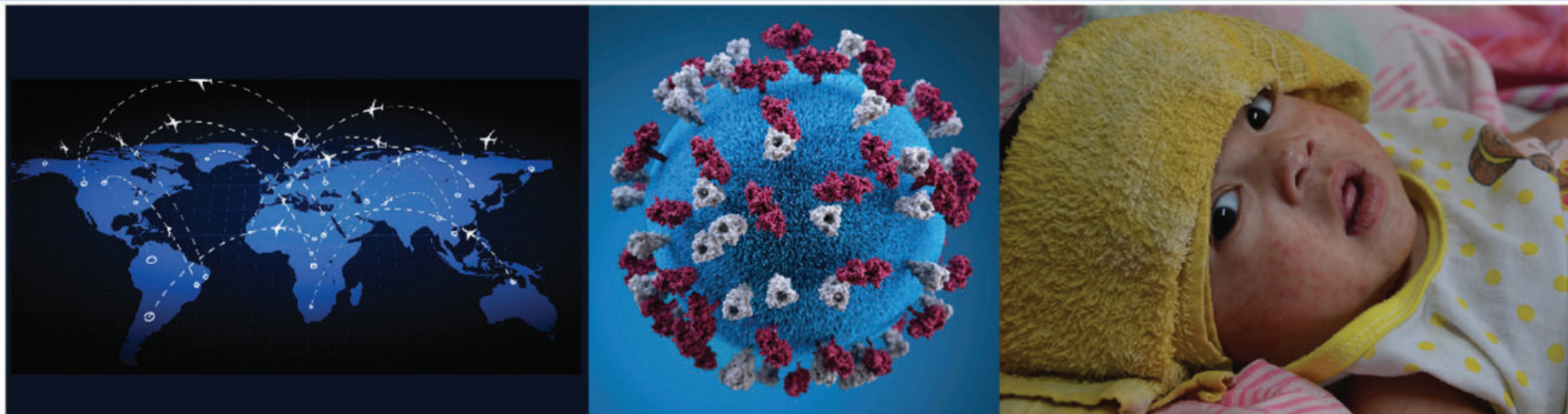


*Source: National update on Measles Cases and Outbreaks – United States, January 1 – October 1, 2019, MMWR, October 4, 2019

Summary

- **Endemic measles has been eliminated in the United States since 2000**
 - However, measles cases continue to occur through global importations
 - Most importations are U.S. travelers who are not fully vaccinated
- **Recent epidemiology suggests larger and more sustained outbreaks compared to earlier post-elimination years**
- **Measles exploits pockets of under vaccination**
 - Multidisciplinary local response needed to prevent measles outbreaks

The 2018–2019 Measles Epidemic in New York State: Successes and Challenges

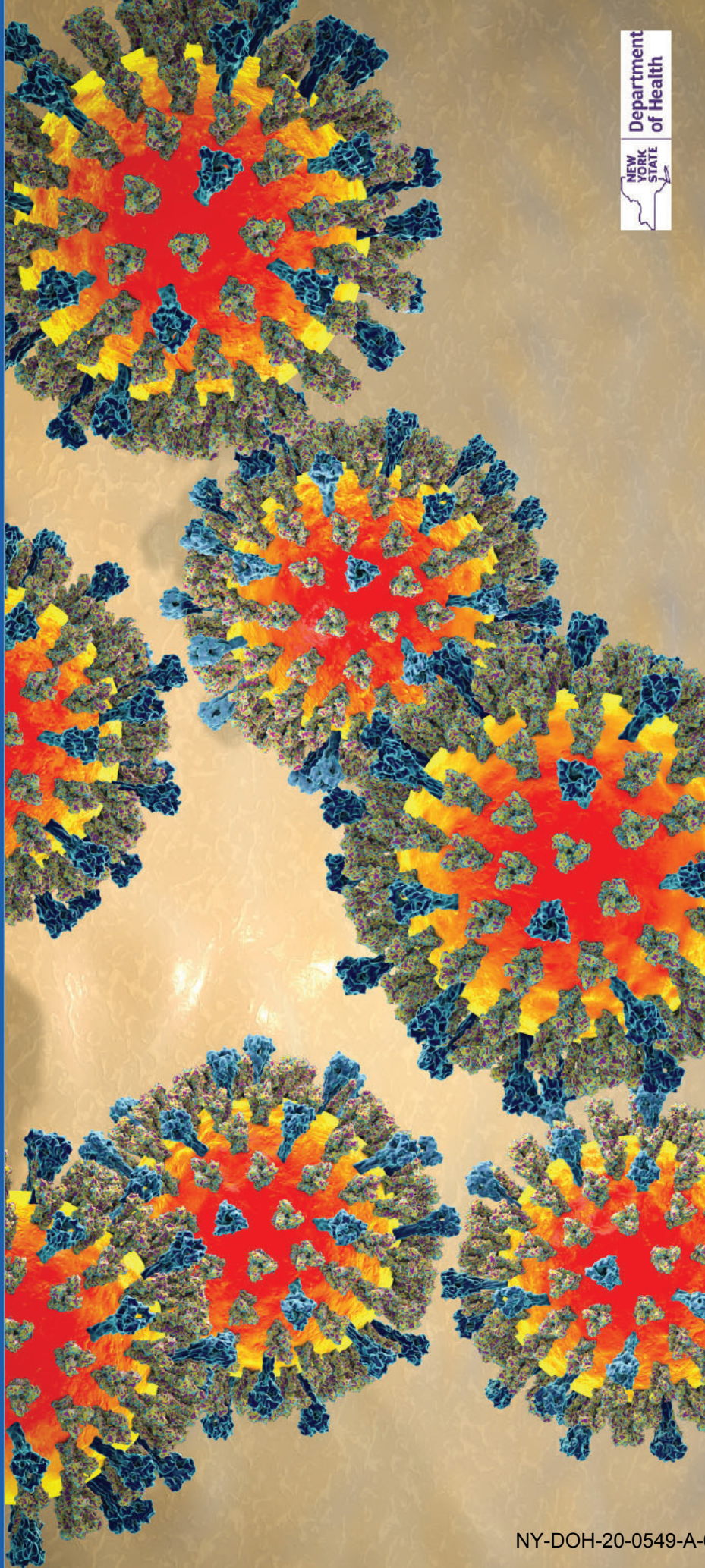


Howard A. Zucker, M.D., J.D.

Commissioner

New York State Department of Health

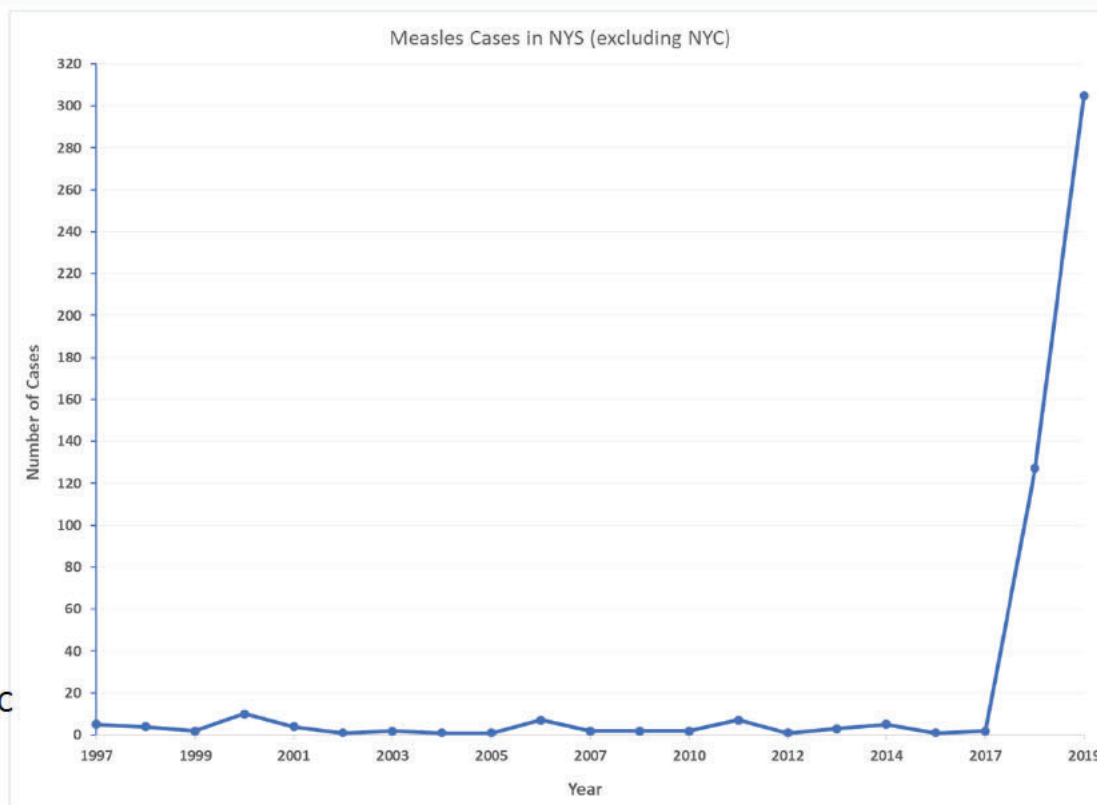
1. Measles and Public Health in New York State



New York's Leadership in Disease Prevention

- **1912:** U.S. begins routine reporting of measles cases; an average of 6,000 measles-related deaths are reported each year over next decade.
- **1914:** New York state's Antitoxin Laboratory designated as Division of Laboratories and Research, facilities that will later become known as **Wadsworth Center**.
- **1926:** Wadsworth develops nation's first system of standardized laboratory analysis for the diagnosis of human disease.
- **pre-1963:** Before licensing of measles vaccine, an estimated 400–500 U.S. residents died of measles each year.

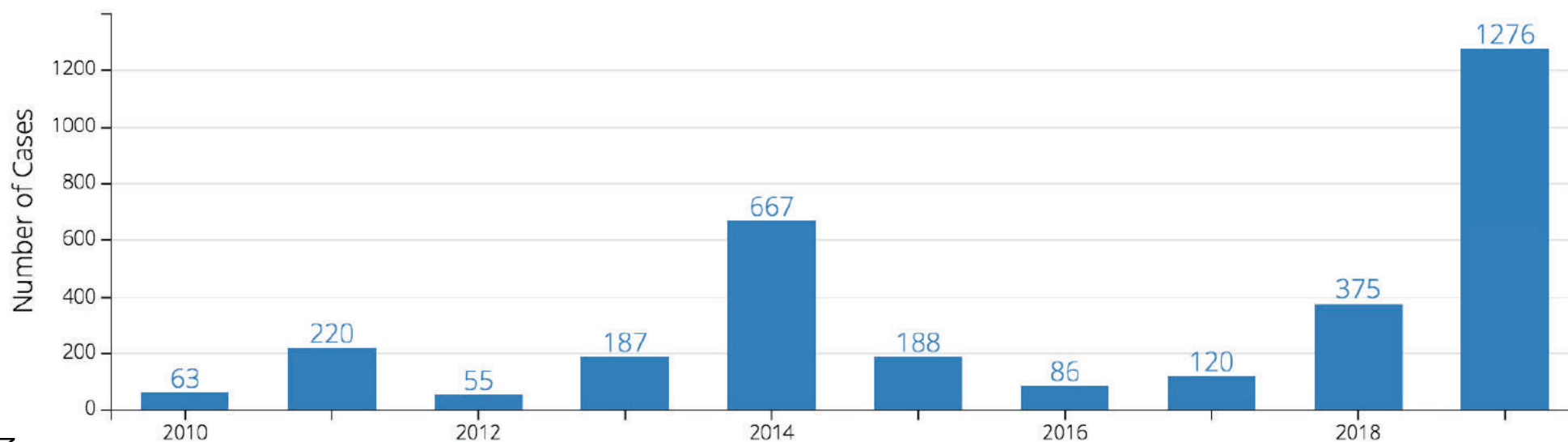
Measles Cases in New York State, 1997–2019*



*As of 12/17/2019; excluding NYC

Measles Cases in the United States, 2010–2019

2010-2019** (as of December 5, 2019)



*Reporting for 2019 began December 30, 2018. Case count is preliminary and subject to change.

Cases as of December 5, 2019. Case count is preliminary and subject to change. **Data are updated monthly.

2. The 2018–2019 Outbreak



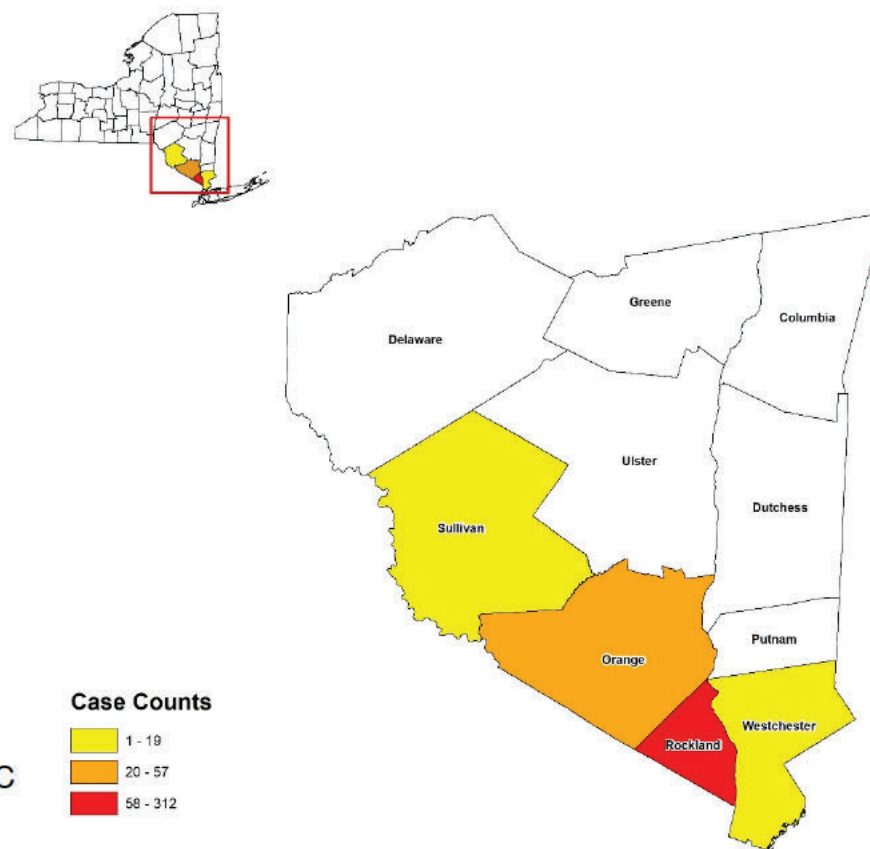
Initial Cases in the Lower Hudson

- **October 1, 2018:** Measles outbreak outside New York City begins in Rockland County when teenager visiting from Israel falls ill during services at local synagogue.
- **October 2018:** Six additional measles cases imported from Israel, including 4 people from one family who become ill at roughly the same time.
- **December 2018–April 2, 2019:** Three further measles importations bring internationally imported cases to 10 during outbreak.
- Outbreak encompasses **4 counties** outside of New York City, all of which have Orthodox Jewish communities.

Measles Outbreak Overview

- **October 1, 2018–October 3, 2019:** A total of **406 people** infected with measles in Rockland (312), Orange (57), Sullivan (19), and Westchester (18) counties.
- Most cases reported in under-vaccinated, close-knit Orthodox Jewish communities.
- **October 1, 2018–October 3, 2019:** county providers administered nearly **85,000 MMR vaccinations**, a 77% increase from the same period during the prior year.
- **October 2019:** County health officials and New York State Department of Health declare outbreak concluded in all 4 counties.

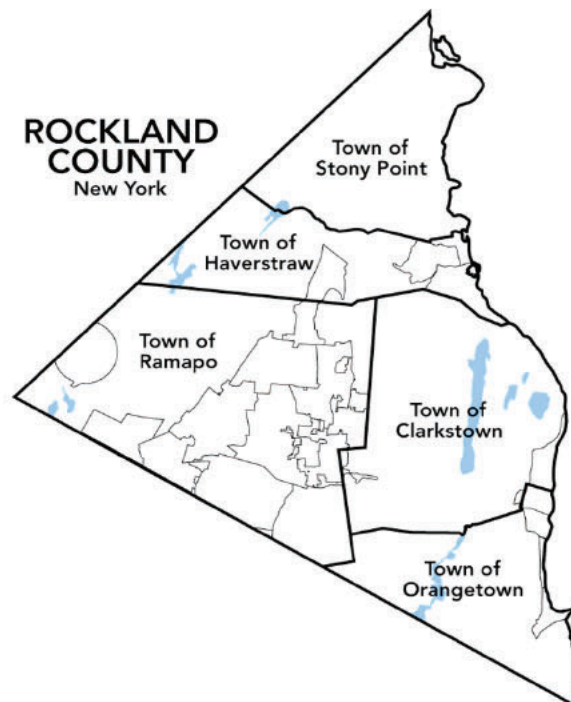
Measles Outbreak Cases by County*



*0/1/2018 – 8/19/2019; excluding NYC

Rockland County as Measles Ground Zero

- **312 cases** confirmed—about 1 in every 1,000 residents.
- Most cases were unvaccinated individuals.
- Nearly **30,000 doses of MMR vaccine** administered during outbreak—3X rate from the same period in the prior year.



Local Heroes: Rockland County Department of Health

“In the beginning, it was a 24/7 operation. The weekends, the nights, the holidays—it didn’t matter.

We lived and breathed measles. We fell asleep thinking of measles, and we woke up thinking of measles.”

— **Dr. Patricia Ruppert**,
Rockland County Health
Commissioner



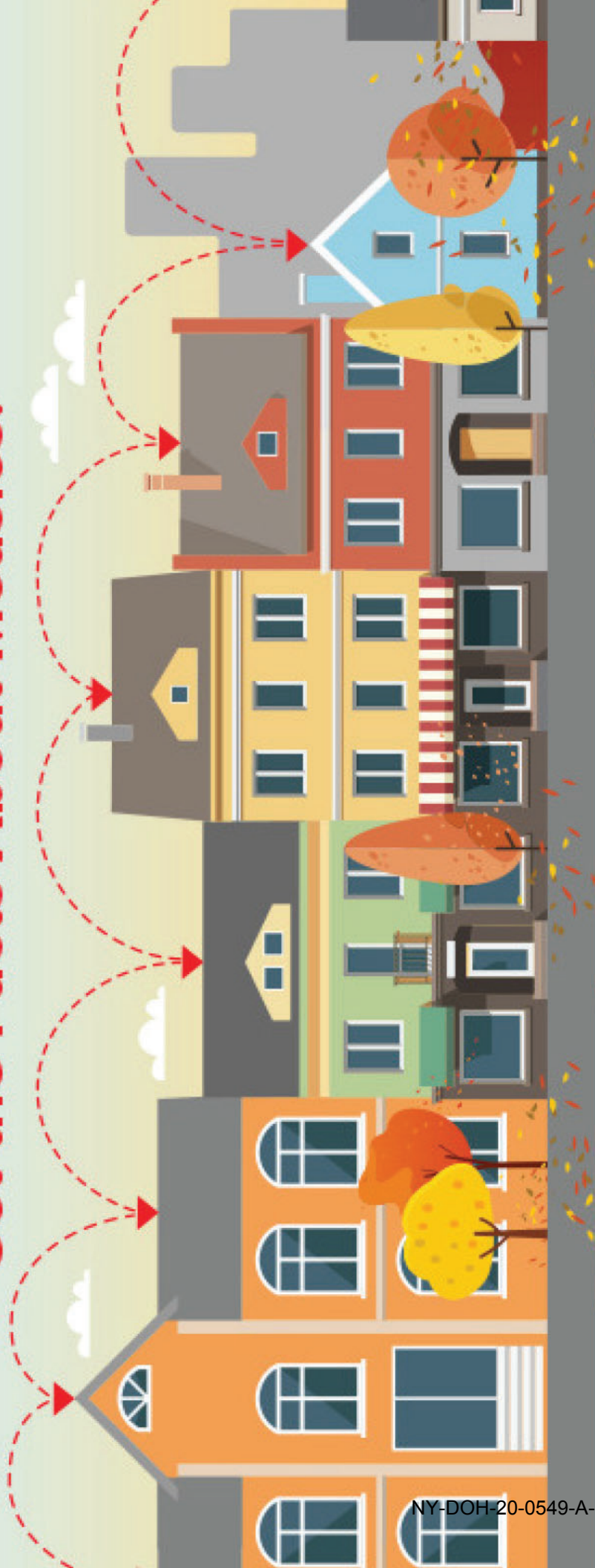
Local Heroes: Refuah Health Center

- Federally Qualified Health Center (FQHC) that provides healthcare to many in Rockland County's Orthodox Jewish community.
- Treated the Israeli boy who was outbreak's index case.
- Doctors and nurses worked closely with department and county officials to vaccinate the unvaccinated.



3. The New York State Response

Get the Facts About Measles.



Department of Health Mobilization Strategy



- Department's **Incident Management System** activated from start of outbreak
- Healthcare Outreach and Communication
- Community Education and Outreach
- Preventing Spread in Schools and at Summer Camps
- New York State Legislative Action

Healthcare Outreach and Communication

- Issued advisories, held conference calls and forums
- Made detailing visits to more than 30 medical practices, urgent care centers, and hospitals
- Provided vaccine to affected counties
- Coordinated specimen lab testing at Wadsworth Center
- Distributed educational materials for patients and families
- Collaborated with Refuah FQHC in Rockland County throughout outbreak

Community Education and Outreach

Printed Educational Materials

- Developed flyers, posters, information postings at malls and highway rest stops, and articles in local publications because digital communication was deemed ineffective for reaching affected demographic.
- Ensured that printed materials were available in English and Yiddish.
- Printed and mailed 90,000 copies of booklets on measles and vaccination to households in affected ZIP codes.
- Distributed 55,000 door hangers to households in affected ZIP codes.

Meetings, Forums, and Conference Calls

- Held conference calls with women in affected communities.
- Met with community, religious and educational leaders in affected counties.

Preventing Spread among Children

In Schools

- Unvaccinated children not admitted to schools or day care centers in outbreak areas, some for entire outbreak.
- Each school in outbreak areas required to confirm compliance weekly. Most schools audited and several fined for noncompliance.
- Rockland County denied unvaccinated children admittance to all schools near schools with measles cases.

At peak of outbreak, Rockland denied 6,000 unvaccinated children entry to 60 schools.

At Summer Camps

- Unvaccinated campers not admitted in high-risk counties.
- Summer population in Sullivan County swells to about 300,000 (from 67,000) because of primarily Orthodox vacationers and campers from NYC.
- Despite this increase, all 300 camps in affected counties were audited.

New York State Legislative Action

- On June 13, 2019, Governor Cuomo signed legislation (S.2994A/A.2371) **removing nonmedical exemptions** from school vaccination requirements for New York state children.
- In August, the Department of Health joined the Office of Children and Family Services to issue **emergency regulations** providing physicians with clear, evidence-based guidance on determining when immunization may be detrimental to a child's health.

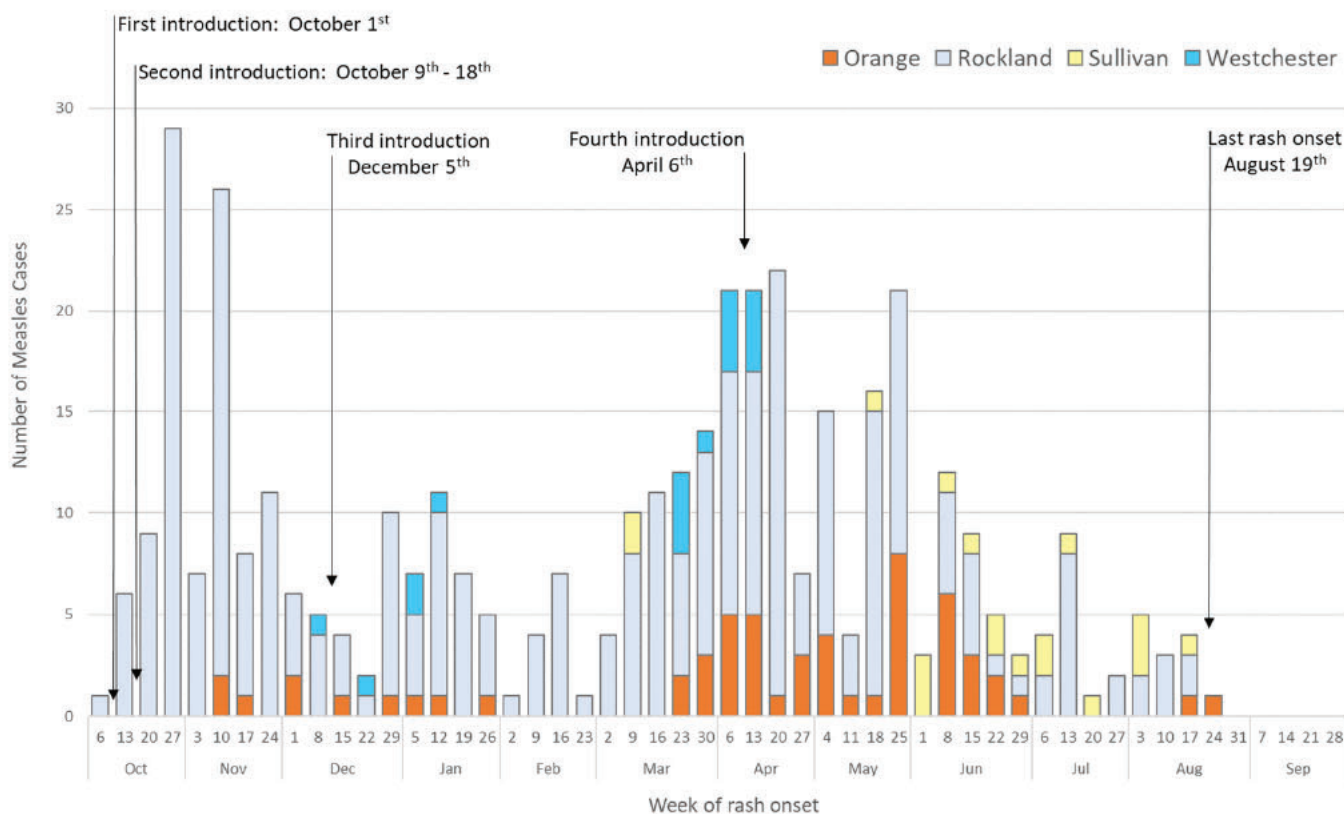


4. Data Analysis



Measles Outbreak Cases by Week of Rash Onset and County

Number of Measles Cases by Week of Rash Onset and County in the Hudson Valley, NYS,
October 1, 2018 – August 19, 2019 (N=406)*



Rates of Vaccination

- New York state has high MMR immunization coverage overall—96% among school-age children.
- Before outbreak, vaccination coverage for children age 1–18 in 4 most affected ZIP codes was **87.3%**.
- Vaccinations during outbreak primarily administered in private practices and FQHCs and public health–held clinics.
- By August 1, 2019, vaccination coverage for children age 1–18 in those ZIP codes increased to **98.3%**.

Measles Outbreak Cases by Age and Vaccination Status*

Age Group	Number of MMR Doses				
	0	1	2	Unknown	Total
<6 months	17	0	0	0	17 (4%)
6-11 months	31	3	0	0	34 (8%)
1-4 years	110	14	3	7	134 (33%)
5-17 years	125	3	2	9	139 (34%)
18+ years	34	4	10	34	82 (20%)
Total	317 (78%)	24 (6%)	15 (4%)	50 (12%)	406

10/1/2018 – 8/19/2019; excluding NYC

Measles-Associated Complications in Outbreak

- No deaths or documented cases of encephalitis.
- 28 (7%) patients diagnosed with pneumonia.
- 28 (7%) patients hospitalized; 20 of them (71%) were children, with 6 (30%) (ranging in age from 1 day to 7 years) admitted to ICU.
- Two women who had measles while pregnant gave birth to preterm infants at 34 and 25 weeks' gestation. Both infants had congenital measles infection confirmed by measles PCR testing.

5. What We Learned

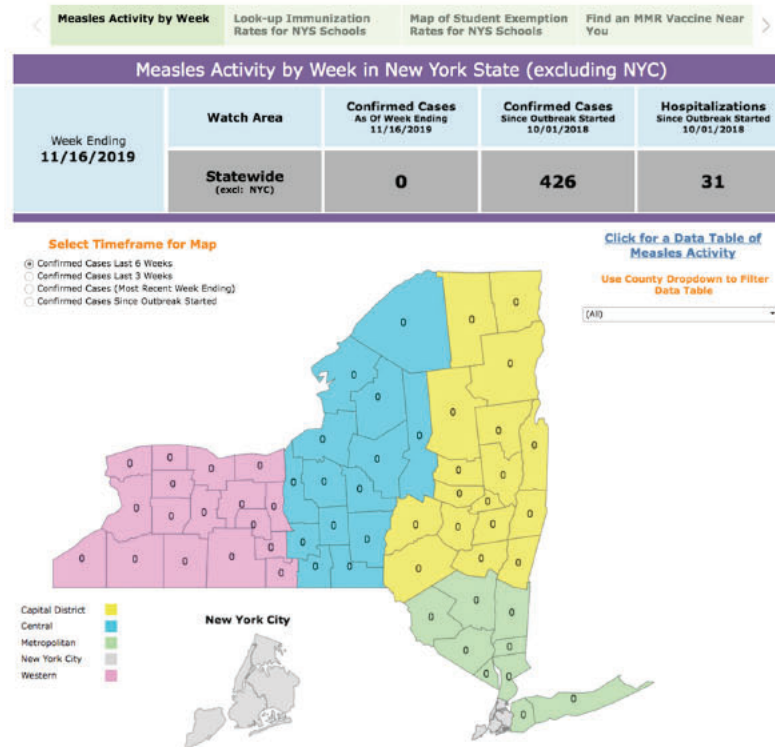


Factors Contributing to Outbreak

- Vaccine hesitancy
- Targeted anti-vaccine activity and misinformation
- Multiple importations following large outbreak in Israel
- Large gatherings
- Close-knit communities
- Large families
- Underreporting and unidentified transmission
- Families did not always seek medical care
- Lab testing limitations

Department Action on Measles

New York State Measles Watch



Critical Steps to Prevent Future Outbreaks



PARENTS: NYS School Vaccination Requirements Have Changed

Nonmedical exemptions to school vaccination requirements have ended for children attending day care and pre-K through 12th grade in New York State. This includes all public, private, and religious schools. Religious exemptions are no longer allowed.

Children with nonmedical exemptions must now be vaccinated to attend or remain in school.

Students who already have all required school vaccinations, and students with a valid medical exemption from a physician, are not affected by this change.



IMPORTANT VACCINATION DEADLINES:

• **Within 14 days of the first day of school or day care** – children must receive the first age-appropriate dose in each immunization series to attend or remain in school or day care.

• **Within 30 days after the first day of school or day care** – parents or guardians must show that they have appointments for the next required follow-up doses for their child. Deadlines for follow-up doses depend on the vaccine.



What vaccines does my child need?

Ask your health care provider. Requirements will differ based on your child's age and any previous vaccinations.



Is it safe for my child to have more than one shot at a time?

Scientific data show that getting multiple vaccines at the same time is safe. It also means fewer doctor's office visits which can be less stressful for your child. Visit health.ny.gov/vaccinesafety to learn more.



Tips to help your child relax at their next shot visit:
www.cdc.gov/vaccines/parents/visit/less-stressful.html
www.cdc.gov/vaccines/parents/tools/tips-factsheet.pdf



Department
of Health

- Ongoing **vigilance** regarding vaccine hesitancy
- Strong **partnerships** and communication channels with county health departments and local healthcare providers
- Removing **nonmedical exemptions** from school vaccination requirements across New York state

Outbreak All-Stars

New York State Department of Health

Debra Blog, Dina Hoefer, Elizabeth Rausch-Phung, Elizabeth Dufort, Patrick Bryant, Nina Ahmad, Lou Smith, Rachel Wester, Kirsten St. George, Jamie Sommer, Karen Southwick, Candace Noonan-Toly, Kimberly Carrasco, Dylan Johns, Stephanie Ostrowski, Eleanor Adams, Brad Hutton

Rockland County Department of Health

Patricia Ruppert, Maria Souto, Kevin McKay, Tatiana Dolinsky

Orange County Department of Health

Lisette McNulty, Irina Gelman, Debbie Fagan

Westchester County Department of Health

Ada Huang, Toby Levin, Sherlita Amler

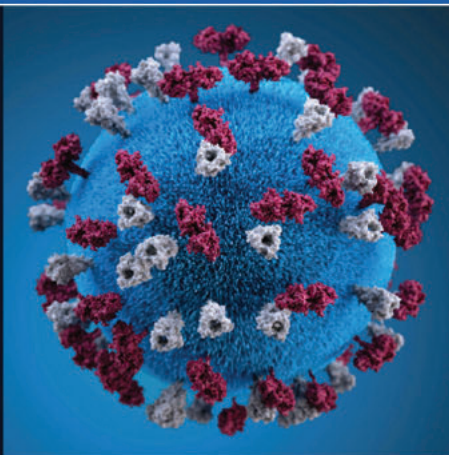
Sullivan County Department of Health

Nancy McGraw

CDC

Manisha Patel, Paul Gastanaduy, Robert McDonald

2018–2019 measles outbreak: The New York City experience



Oxiris Barbot, MD

Commissioner

New York City Department of Health and Mental Hygiene



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

OVERVIEW

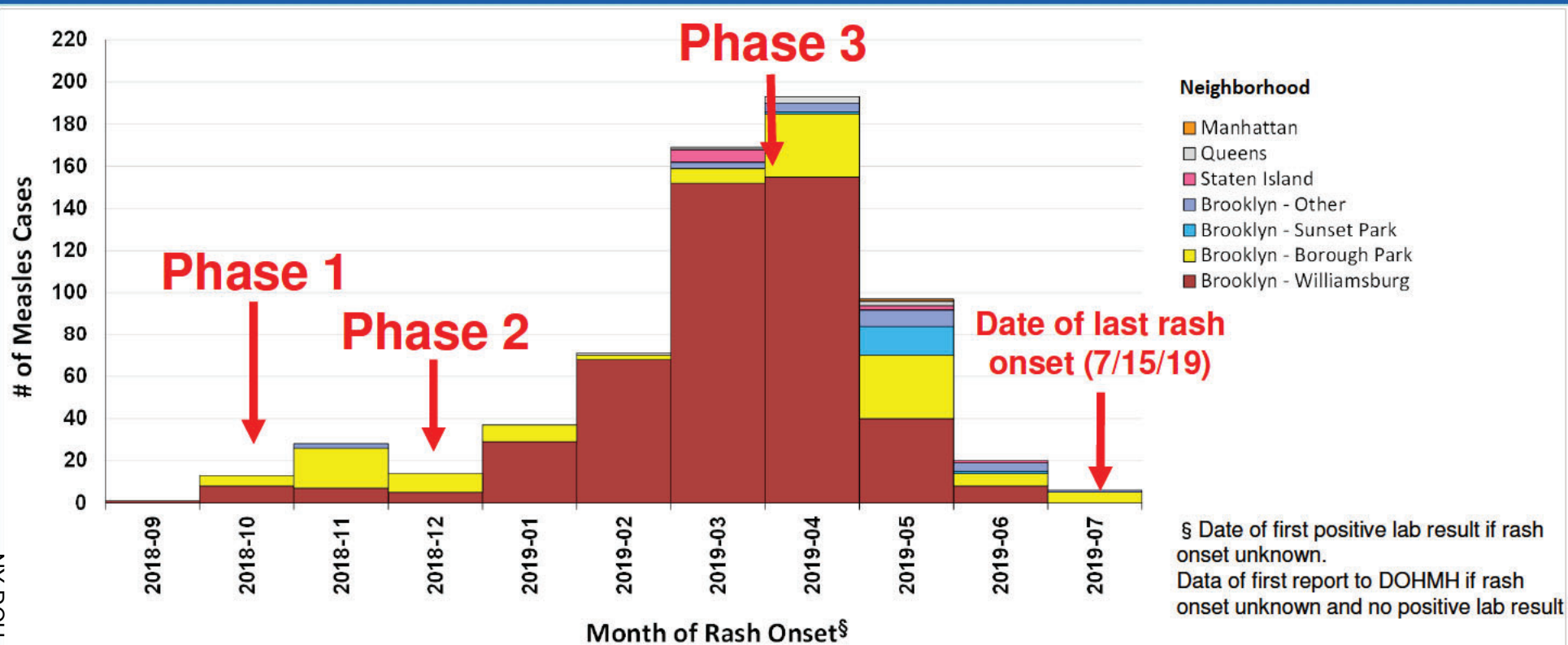
- Geographic distribution and demographic description of cases
- Complications among affected persons
- Factors that led to the outbreak
- Twofold DOHMH response:
 - Measles virus
 - Vaccine misinformation
- Lessons learned
- Future challenges

LOCATIONS OF MEASLES OUTBREAKS

- First case had rash onset on Sept. 30, 2018
 - Unvaccinated child who returned from Israel
- Centered in two Orthodox Jewish neighborhoods in Brooklyn



MEASLES CASES BY DATE OF RASH & NEIGHBORHOOD (N=649)



Source: NYC DOHMH surveillance data, as of 9/25/19.

DEMOGRAPHICS OF CASES (N=649)

Characteristics**n (%)****Age Category:**

<1 year 102 (16)

1 to 4 years 277 (43)

5 to 19 years 146 (22)

≥18 years 124 (19)

VACCINATION STATUS OF CASES (N=649)

- Unvaccinated: 476 (86%)*
 - Age <12 months: 100
 - Age $\geq$ 12 months: 376 Preventable Cases
- Vaccinated: 79 (14%)*
 - 1 prior MMR: 46
 - 2 prior MMR: 33
- Unknown vaccination history (primarily adults): 94

*% among cases with known vaccination status, as of December 20, 2019

PERSONS EXPERIENCING COMPLICATIONS

- Hospitalizations: 49 (8%)
 - 20 ICU admissions
- Pneumonia: 37 (6%)
- Otitis media: 63 (10%)
- Diarrhea: 92 (14%)
- No cases of encephalitis or deaths have occurred

WHY DID THIS OUTBREAK OCCUR?

- **Low herd immunity in a densely populated, relatively closed community with large young households**
 - Existing coverage low, vaccination delay until school enrollment
 - Religious exemptions have almost tripled in past 6 years
 - Citywide from 0.5% in 2012–13 to 1.5% in 2018–19
 - In Orthodox Jewish schools, from 0.7% in 2012–13 to 2.7% in 2018–19; some schools had religious exemptions as high as 28%

WHAT MADE THIS RESPONSE SO COMPLEX?

- Multiple importations (Israel, UK, Ukraine, NY, NJ)
- Multiple exposures (>20,000 exposures) and chains of transmission (>100 chains)
- Vaccine hesitancy fueled by vaccine misinformation cloaked in religious terms
- Parents not bringing children for care or providing exposure information, precluding control measures

DOHMH RESPONSE: MEASLES OUTBREAKS

1. Clinical
2. School or day care
3. Legal
4. Communication

DOHMH RESPONSE: MEASLES OUTBREAKS

CLINICAL

- Clinical and infection control consultation
- Technical assistance to facilities or providers serving the affected communities
- Assist with postexposure prophylaxis for exposed persons

SCHOOL AND CHILD CARE

- Exclusion of unvaccinated students with medical or religious exemptions from schools, communities with active measles cases

APRIL 9, 2019: PUBLIC HEALTH EMERGENCY DECLARED

- Every adult and child who lives, works, or resides in Williamsburg and has not received the MMR vaccine must be vaccinated
- Exception: People who demonstrate they are immune from measles or have a valid medical exemption
- Last public health emergency ordered people to get vaccinated against smallpox ~1901



DOHMH RESPONSE: MEASLES OUTBREAKS

LEGAL

- Five parents challenged vaccination order
- On April 18, 2019, Justice Lawrence Knipel denied motion for an injunction and dismissed their challenge finding:
 - Williamsburg at “the epicenter” of “the most significant spike in incidences in the United States in many years”
 - Petitioners unable to offer better, less restrictive alternative
 - Medical objections not supported by science
- Appellate Division denied temporary restraining order on April 30, 2019, and motion for preliminary injunction on May 13, 2019

DOHMH RESPONSE: VACCINATION MISINFORMATION

COMMUNICATION

- Community collaboration
 - Religious leaders
 - Met with rabbinical and community leaders, elected officials
 - Medical partnerships
 - Jewish Orthodox Women's Medical Association and Vaccine Task Force
 - Pediatric care practices
- Information disseminated through various outlets

DOHMH RESPONSE: VACCINATION MISINFORMATION

- WHO declared vaccine hesitancy as top 10 threat to global health
- Anti-vaxxers infiltrated ultra-Orthodox Jewish community
 - Robocalls and flyers conveying false information spread throughout community
 - **P**arents **E**ducating and **A**dvocating for **C**hildren's **H**ealth, an anti-vaccine organization, led efforts to intensify vaccine hesitancy

DOHMH RESPONSE: “A SLICE OF PIE”

A
SLICE
OF
PIE

Parents Informed & Educated

Making PIEs Out of PEACH:
MMR EditionBringing Current and Reliable
Vaccine Information to Frum FamiliesA project of the EMES Initiative
May 2019

VACCINE SAFETY

How Do I Know Vaccines Are Safe?

Just like all drugs, vaccines undergo a lot of scrutiny before being approved. It takes many years, from the application process, all the way through all the stages of testing, to receive approval for use on humans. Once a vaccine is approved, that is not the end of the monitoring. Several organizations oversee the manufacturing, and continually gather information on all vaccines to ensure safety and effectiveness.

Here are some organizations that monitor vaccine safety:

The following organizations monitor vaccine safety: the Food and Drug Administration, Centers for Disease Control and Prevention, National Institutes of Health, and the Department of Defense, among others. There are surveillance systems to identify vaccine safety concerns, including: Vaccine Adverse Event Reporting System (VAERS), Vaccine Safety Datalink (VSD), Post-Licensure Rapid Immunization Safety Monitoring (PRISM), and the Clinical Immunization Safety Assessment (CISA) Project.

Anti-Vaxx Myth: There are no safety studies or any real way to know if vaccines are safe.

PIE: False. Vaccines are studied and monitored from the very beginning and go through years of safety testing in labs and clinical trials before they go to market. Once the vaccine is approved, the manufacturer tests batches of the vaccine for quality and safety before the FDA can recommend it for use. Once the vaccine goes to market, multiple agencies monitor its safety and provide additional checks. *Source:* HHS, 2017b

Anti-Vaxx Myth: “It is rare for a vaccine to be removed from circulation, no matter how much damage it is causing.”

PIE: False. As with any drug, not all adverse effects will occur during clinical trials. Therefore, once a vaccine is made available to the public, information is continually gathered to identify problems after marketing begins. Although vaccines rarely cause long-term harm, there have been a few cases where a specific vaccine was found to be unsafe once they were already in use. In these cases, the vaccine was immediately removed from circulation.

Source: HHS, 2017b; Offit, 2005; CDC, 2015

Is there any connection between autism and vaccines?

In 1998, a study by Andrew Wakefield, then a consultant gastroenterologist, was published in the *Lancet*, a British medical journal. He studied 12 children whose parents claimed they noticed behavioral regression and gastrointestinal symptoms after their children received the MMR vaccine. After publishing his study, Wakefield then held a press conference where he stated that the MMR vaccine was unsafe, and advocated the use of single-antigen vaccines (i.e., separating the measles, mumps, and rubella into three separate vaccines).

Source: Dyer 2010; Wakefield, 1998

Wakefield’s study, however, never concluded that MMR caused either autism or the gastrointestinal problems. To the contrary, Wakefield actually made the following statement in his study: **“We did not prove an association between measles, mumps, and rubella vaccine and the syndrome described.”** He also concluded that, “A genetic predisposition to autistic-spectrum disorders is suggested by over-representation in boys and a greater concordance rate in monozygotic [identical] than in dizygotic [fraternal/non-identical] twins.”

Source: Dyer 2010; Wakefield, 1998

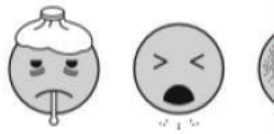
DOHMH RESPONSE: MEDIA CAMPAIGNS

ATTENTION MEASLES OUTBREAK

GET VACCINATED

IF YOU HAVE

fever, cough, red eyes,
runny nose and body



PLEASE CONTACT YOUR
DOCTOR IMMEDIATELY

NYC
Health

אין אינאיינעם אפשטעלן

מזעלס

מענטש מיט מזעלס קען אנשטעקן
מענטשן וואס זענען נישט אימיון.



ווערט היינט וואקסירט.
ווערט נישט געוואקסירט.

SPREAD THE TRUTH NOT MEASLES

There is no link between
autism and vaccines.

PROTECT YOURSELF, YOUR FAMILY AND YOUR COMMUNITY.
GET VACCINATED TODAY.
CONTACT YOUR DOCTOR IMMEDIATELY.

NYC
Health

TOGETHER WE CAN STOP MEASLES

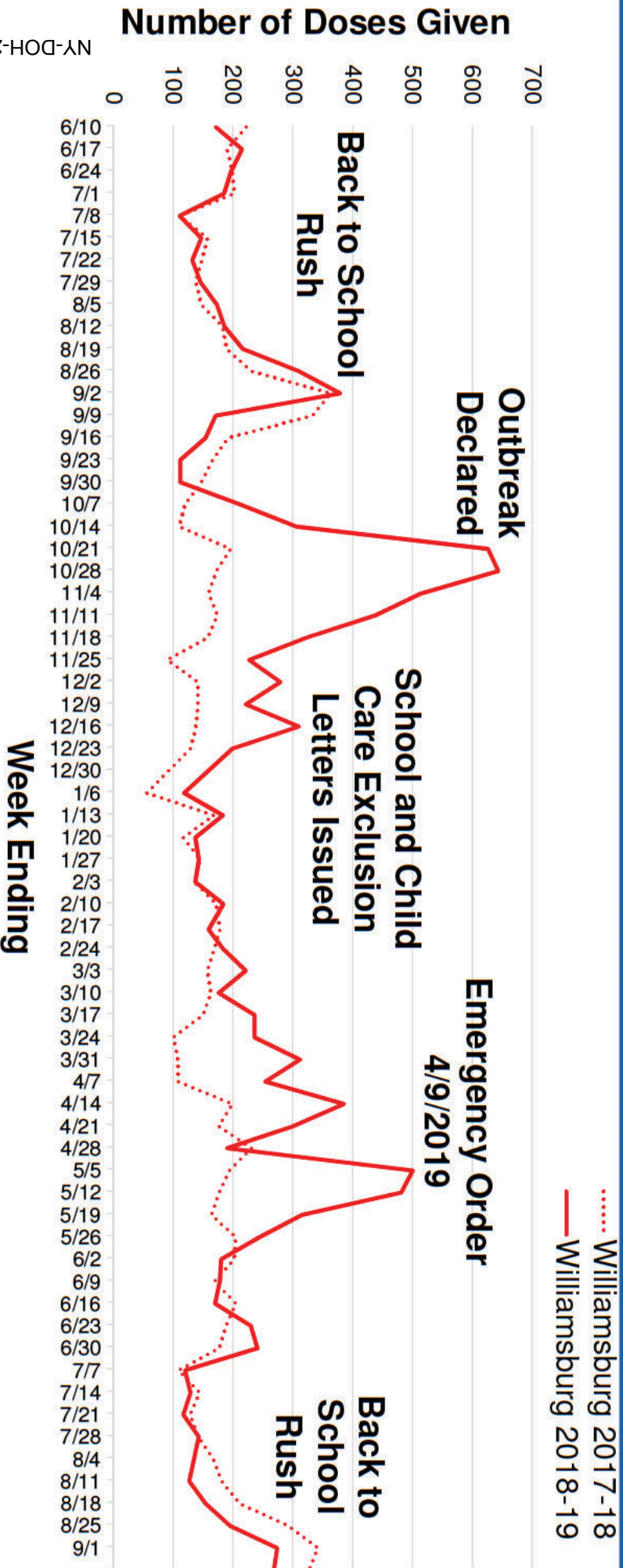
One person with measles can infect an average
of 12 to 18 people without immunity.



PROTECT YOURSELF, YOUR FAMILY AND YOUR COMMUNITY.
GET VACCINATED TODAY.
CONTACT YOUR DOCTOR IMMEDIATELY.

NYC
Health

DOHMH RESPONSE: MMR VACCINE UPTAKE



Source: NYC DOHMH Citywide Immunization Registry, data as of 9/1/2019, run on 9/3/2019

DOHMH RESPONSE: BY NUMBERS

- ~ 560 DOHMH staff deployed
- ~ 104,000 person-hours spent
- 2,279 suspect cases of measles investigated
- >3,200 diagnostic tests performed by DOHMH labs
- Agency spent \$8.4 million to end outbreak
 - Actual cost to community much greater

LESSONS LEARNED

- Decades old public health victories cannot be taken for granted
- More granular surveillance and immunization coverage data key to early identification of susceptible populations
- Leverage community relationships to build new alliances

FUTURE CHALLENGES

- Vaccine hesitancy requires resources for continued education in vulnerable communities
- Ongoing risk of international importation
- Implementation of state law removing religious exemptions and NYC health code changes requiring DOHMH review of all medical exemptions

SPECIAL THANKS TO...

➤ **Division of Disease Control**

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➤ **Office of Emergency, Preparedness & Response**

Beth Maldin Morgenthau, M.P.H.

➤ **Division of Environmental Health**

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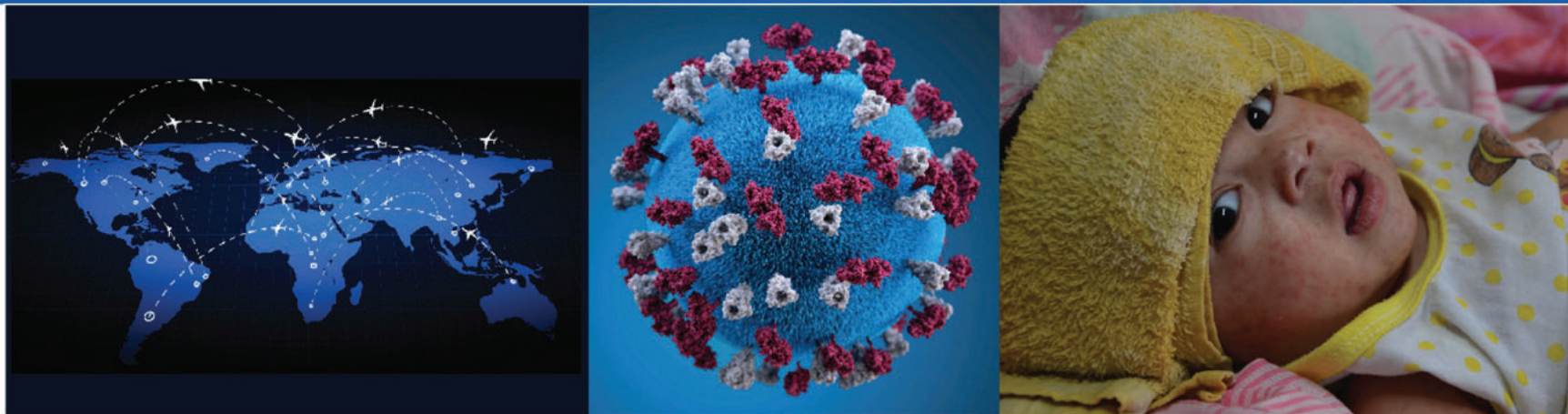
➤ **Office of General Counsel**

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➤ **Office of External Affairs**

Maura Kennelly, M.P.H.

Strengthening Confidence in Vaccines



Amanda Cohn, MD (CAPT, USPHS)

Chief Medical Officer

National Center for Immunization and Respiratory Diseases



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

Vaccine coverage is high in the United States

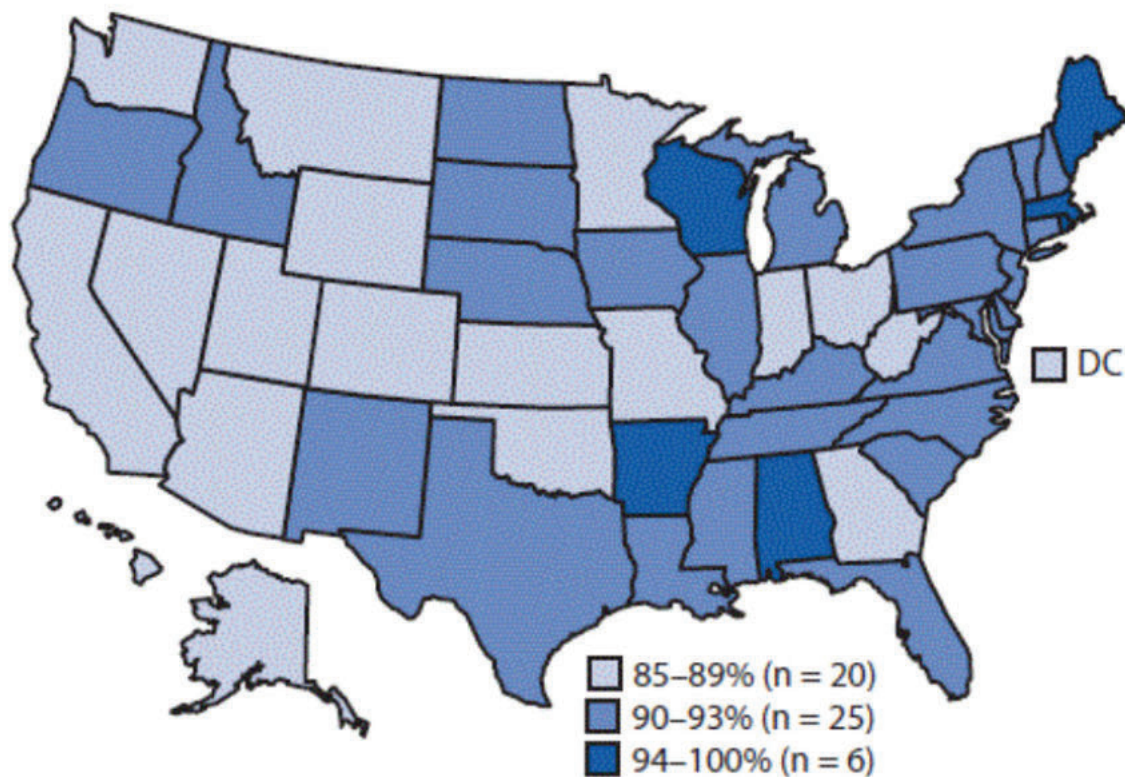
- **Nearly 99% of U.S. children have received some vaccines by the age of 2 years**
- **Over 94% of kindergarteners have received 2 doses of measles, mumps, and rubella vaccine (MMR) and the state-required number of doses of diphtheria, tetanus, and acellular pertussis (DTaP) and varicella vaccines**

Seither et al, MMWR, October 17, 2019

Figure adapted from Gabriele Malaspina, the Noun Project

Some children remain unprotected

≥1 Dose MMR vaccination coverage by 24 months among children born in 2015–2016

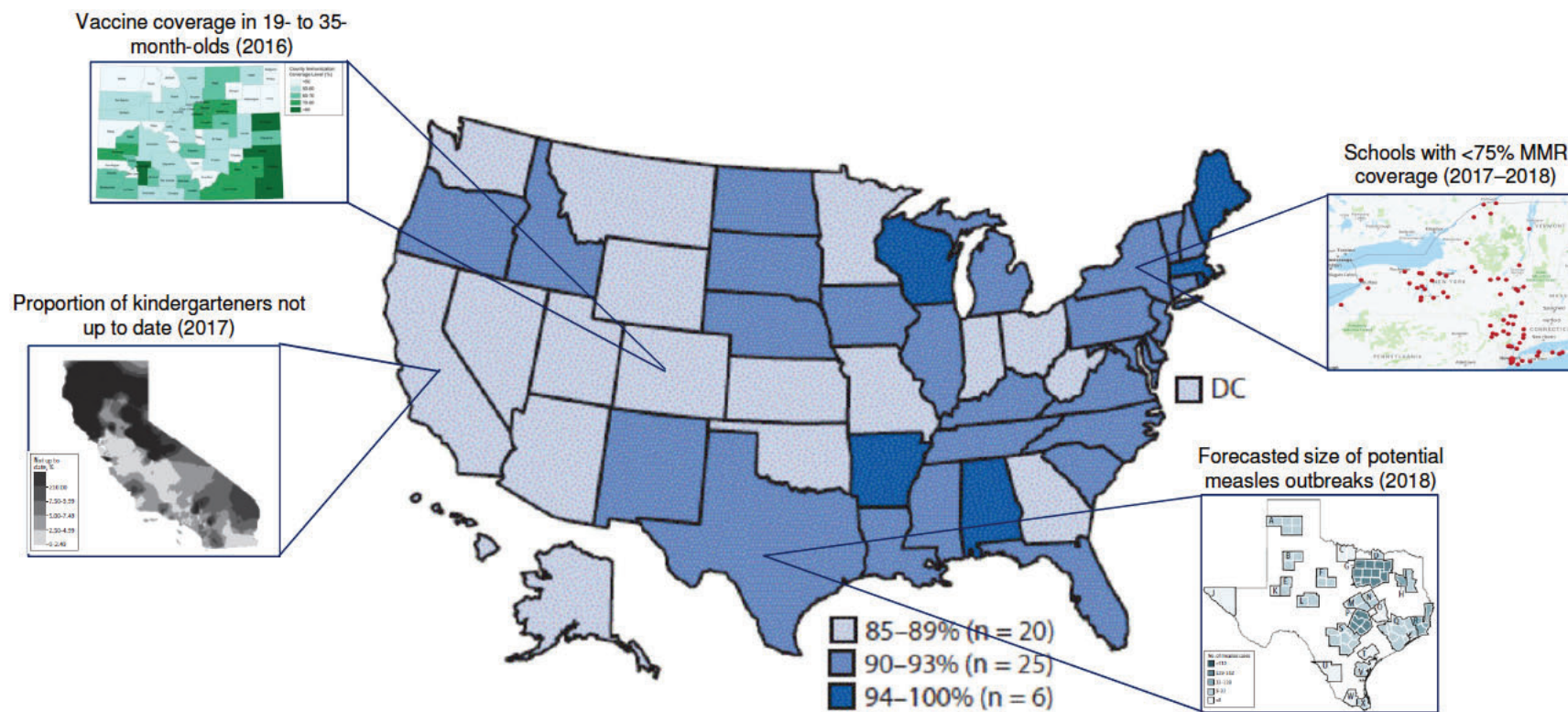


Nationwide coverage: 90.4%

Lower in children who are:

- Uninsured/underinsured
- Reside in rural area
- Live below poverty level

Pockets of low vaccination threaten communities



Source: National Immunization Survey
New York State Student Identification System
Sinclair D, et al. JAMA network open. 2019
Pingali S, JAMA. 2019

Characteristics of Low Vaccination Pockets



- ❑ **Each community is unique**, with distinct factors affecting vaccination:
 - Close-knit
 - Isolation or insularity
 - Access issues
 - Distrust of public authorities
 - Localized misinformation

Myths and misinformation

- ❑ Myths have always been part of the vaccine landscape
- ❑ But **rapid dissemination and sophistication** of misinformation present new challenges
 - Internet access
 - Social media
 - Talk radio and television
- ❑ Misinformation plays a clear role in eroding vaccine confidence and puts our programs at risk



Vaccine misinformation can be tailored for specific communities

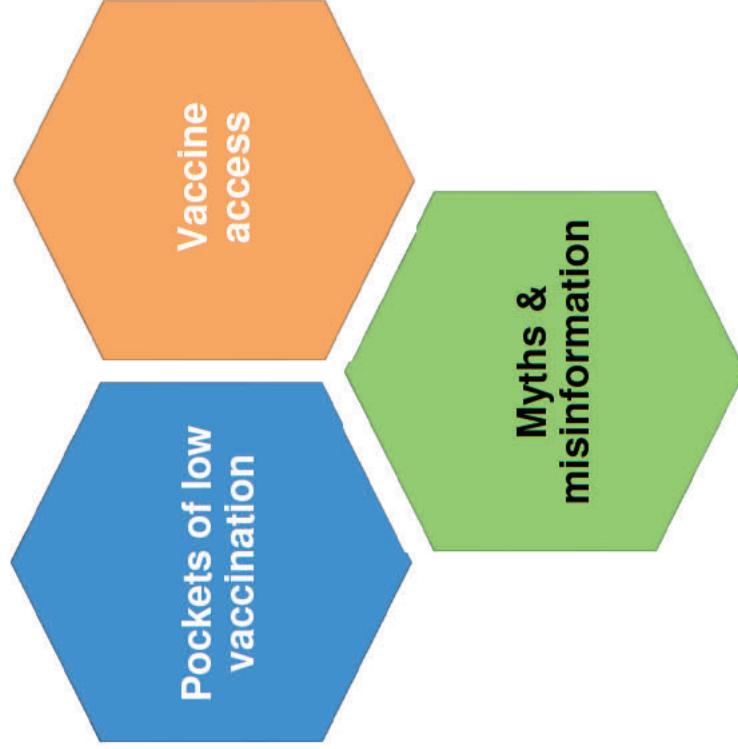


Vaccinate with **Confidence**

Protect communities. Empower families. Stop myths.

CDC's strategic framework for strengthening vaccine confidence and preventing outbreaks of vaccine-preventable diseases in the United States

Lessons learned from recent outbreaks





Vaccinate with **Confidence**

Protect communities. Empower families. Stop myths.

Protect communities

Use every tool available to find and protect communities at risk using tailored, targeted approaches

Empower families

Ensure parents are confident in decision to vaccinate by strengthening provider-parent vaccine conversations

Stop myths

Use local partners and trusted messengers, establish new partnerships to contain the spread of misinformation, and educate critical stakeholders about vaccines



Vaccinate with **Confidence**

Protect communities

- ✓ Leverage immunization data to find and respond to communities at risk
- ✓ Work with trusted local partners to reach at-risk communities before outbreaks
- ✓ Ensure vaccines are available, affordable, and easy to get in every community



Vaccinate with Confidence

Protect communities

- ✓ Leverage immunization data to find and respond to communities at risk
- ✓ Work with trusted local partners to reach at-risk communities before outbreaks
- ✓ Ensure vaccines are available, affordable, and easy to get in every community

Empower families

- ✓ Expand resources for healthcare professionals to help them have effective vaccine conversations with parents
- ✓ Work with partners to start conversations before the first vaccine appointment
- ✓ Help providers foster a culture of immunization in their practices



Vaccinate with **Confidence**

Protect communities

- ✓ Leverage immunization data to find and respond to communities at risk
- ✓ Work with trusted local partners to reach at-risk communities before outbreaks
- ✓ Ensure vaccines are available, affordable, and easy to get in every community

Empower families

- ✓ Expand resources for healthcare professionals to encourage effective vaccine conversations with parents
- ✓ Work with partners to start conversations before the first vaccine appointment
- ✓ Help providers foster a culture of immunization confidence in their practices

Stop myths

- ✓ Work with local partners and trusted messengers to improve confidence in vaccines among key, at-risk groups
- ✓ Work with social media outlets to promote trustworthy vaccine information
- ✓ Provide accurate, accessible information on vaccines to state policy makers
- ✓ Engage state and local health officials to advance effective local responses to misinformation

CDC Progress to Date

- **Assisted states and cities to respond to the worst year for measles since 1992**
- **Developed state and local health department, healthcare provider, and camp toolkits**
- **Worked with key partners to get their perspectives on vaccine hesitancy challenges**
- **Developed strategic framework to strengthen vaccine confidence**
- **Funded new work by key partners to implement immediate efforts**



Picture courtesy of AAP and SELF Magazine.

CDC Priorities



Picture courtesy of AAP and SELF Magazine.

- ❑ Leverage diverse data sources to find and protect communities at risk
- ❑ Expand resources for working with communities
- ❑ Build and foster a culture of immunization in healthcare practices
- ❑ Provide technical assistance to funded partners
- ❑ Strengthen communication strategies
- ❑ Further invest in our vital partners

Partnership is key

- ❑ To truly keep Americans safe, every generation, community, and child needs to be appropriately immunized
- ❑ Together, we can protect our communities, empower families, and stop myths



Picture courtesy of AAP and SELF Magazine.

Thank you



Vaccinate with **Confidence**

Protect communities. Empower families. Stop myths.

For more information, contact CDC

1-800-CDC-INFO (232-4636)

TTY: 1-888-232-6348 www.cdc.gov

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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Upcoming Programs of Interest

March 17, 2020

**Public Health Grand Rounds
Laboratory Response Network**

April 21, 2020

**Public Health Grand Rounds
Predictive Analytics and Public Health**

May 19, 2020

**Public Health Grand Rounds
Smoking Cessation: New Insights and Future Directions**

From: [HHS Region 2](#)
To: [Zucker, Howard A \(HEALTH\)](#)
Subject: Fiscal Year 2021 Proposed Budget
Date: Monday, February 10, 2020 5:14:55 PM

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Dear partners,

Today, the Trump Administration released our FY 2021 Budget. Health and Human Services Secretary Alex Azar issued the following statement regarding the release of the Budget:

"President Trump's FY 2021 Budget aims toward a future where HHS's programs work better for the people we serve; where America's healthcare system is affordable, personalized, puts patients in control, and treats you like a human being, not a number; and where our human services programs put people at the center. The President's Budget proposes to protect what works in our healthcare system and make it better, by paying for value and empowering patients to get better care at a lower cost. Continuing the President's success in making an impact on key public health challenges, the Budget proposes investments to end the HIV epidemic in America by 2030, bring down the rate of drug overdose deaths further, and combat challenges like rural health disparities and poor maternal health outcomes. The Budget makes difficult, prudent choices about what to do with taxpayer dollars, targeting investments in programs that have proven effective and cutting back on programs that have not." Find HHS's FY2021 Budget in Brief [here](#).
Some of the highlights of the budget are below:

Advancing American Kidney Health

To support the Department's kidney initiative announced in July 2019, the Budget includes \$39 million across multiple HHS agencies and requests new legislative authority in support of the initiative's three goals:

- Reduce the number of Americans developing End-Stage Renal Disease (ESRD) by 25 percent by 2030.
- Have 80 percent of new ESRD patients in 2025 receive dialysis at home or a transplant.
- Double the number of kidneys available for transplant by 2030.

Transforming Rural Health

The Budget supports rural communities through programs such as the Rural Communities Opioids Response and the Telehealth Network Grant Program at HRSA, which supports substance abuse prevention, treatment, and recovery services in high-risk rural communities, as well as promoting telehealth technologies for healthcare delivery. The Budget looks to address the unique health challenges faced by Rural Americans, including hospitals that are closing or in danger of closing; difficulty recruiting and retaining physicians, nurses, and other providers; and increased likelihood of dying from many leading causes of avoidable death such as cancer and heart disease. The President and the Secretary understand that telehealth services make rural health programs more effective, increase the quality of healthcare, and improve health outcomes. The Budget seeks to remove barriers to telehealth services in rural and underserved areas through a proposal to expand telehealth services in Medicare fee-for-service advanced payments models with more than nominal financial risk.

HHS's 4-Point Strategy to Transform Rural Health builds on current HHS initiatives in the following areas:

- Build a Sustainable Health Model for Rural Communities;
- Leverage Technology and Innovation;
- Focus on Preventing Disease and Mortality; and
- Increase Rural Access to Healthcare.

Combating the Opioid and Methamphetamine Crisis

The Budget requests \$5.2 billion to address the opioid overdose epidemic, including \$169 million in new resources. Funding expands State Opioid Response grants in SAMHSA to provide direct treatment, recovery support services, and relapse prevention. The Budget provides funding to HRSA for Addiction Medicine Fellowships to support approximately 60 fellows annually in under served, community-based settings that integrate primary care with mental health and substance use disorder prevention and treatment services.

To allow flexibility to most effectively combat substance abuse in whatever form it takes, SAMHSA's State Opioid Response grant program has the flexibility to also address stimulants. HHS would direct \$50 million within NIH for research to develop medication-assisted treatment and evidence-based psychosocial treatment for methamphetamines and other stimulants.

Ending the HIV/AIDS Epidemic

The Budget invests \$716 million in dedicated funding for the second year of the Ending the HIV Epidemic: A Plan for America initiative, an increase of \$450 million from FY 2020. This funding expands activities in the 57 target jurisdictions to increase HIV testing and access to prevention and treatment services.

Improving Maternal Health

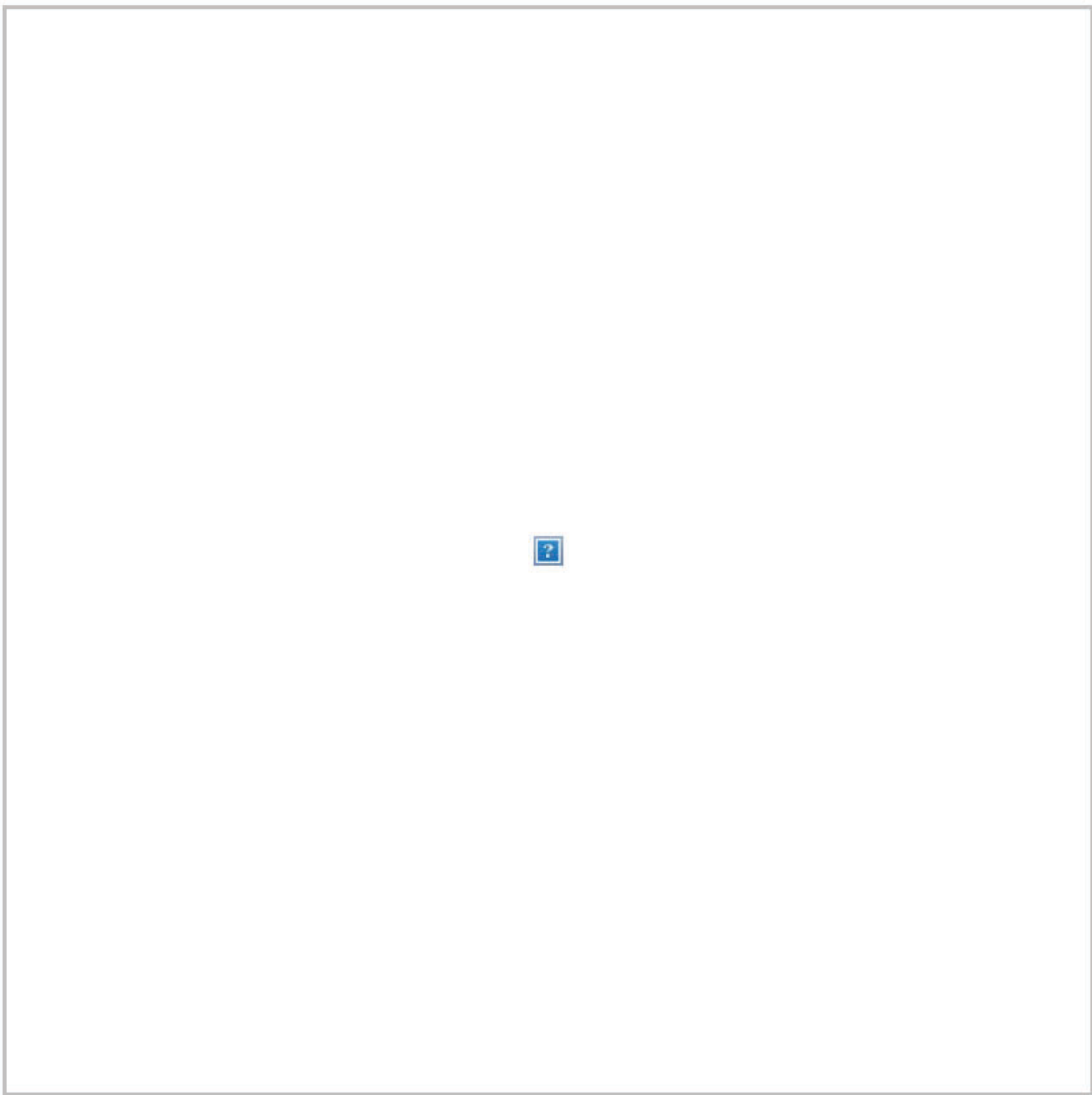
The Budget emphasizes the Administration's commitment to reducing the rates of maternal mortality and morbidity. The Administration's Improving Maternal Health in America initiative is addressing this significant public health problem. This initiative focuses on four strategic goals:

- Achieve healthy outcomes for all women of reproductive age by improving prevention and treatment;
 - Achieve healthy pregnancies and births by prioritizing quality improvement;
 - Achieve healthy futures by optimizing postpartum health; and
 - Improve data and bolster research to inform future interventions.
- The Budget provides a total of \$116 million for this initiative across the National Institute for Research on Safety and Quality (NIRSQ), the CDC, HRSA, and IHS.

Strengthening the Indian Health Service

The Budget emphasizes the Administration's commitment to the health and wellness of Native Americans and the operations of IHS. This population continues to experience significant health disparities, and the Budget includes key investments to ensure quality of care. The Budget invests \$6.2 billion in IHS, which includes \$125 million for electronic health record modernization, provides funding to support IHS Services, Ending the HIV Epidemic, and Maternal Health, and includes \$125 million for high-priority healthcare facilities construction projects.

Best,
HHS Region II



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From: CDC IMS State Coordination Task Force (SCTF) Operations

Sent: Monday, February 10, 2020 9:20 AM

To: Avchen, Rachel (CDC/DDPHSIS/CPR/DSLR) <rja5@cdc.gov>; Hamilton, Janet (CDC cste.org) <jhamilton@cste.org>; Peart, Jordan (CDC cste.org) <jpeart@cste.org>; Shah, Dhara (CDC cste.org) <dshah@cste.org>; Butler, Jay C. (CDC/DDID/OD) <jcb3@cdc.gov>; Dreyzehner, John (CDC/DDPHSIS/CPR/OD) <PWN3@cdc.gov>; Williams, Ian (CDC/DDID/NCEZID/DFWED) <iaw3@cdc.gov>; Berger, Sherri (CDC/OCOO/OD) <sob8@cdc.gov>; Bowman, Thomas (OS/ASPR/EMMO) <Thomas.Bowman@hhs.gov>; Weir, Charles (OS/ASPR/IO) <Charles.Weir@hhs.gov>; Maples, David L. (CDC/DDPHSIS/CPR/DEO) <idr0@cdc.gov>; CDC IMS State Coordination Task Force (SCTF) Policy & Comm <eocscfpolcomm@cdc.gov>; CDC IMS State Coordination Task Force (SCTF) Lead <eocscflead@cdc.gov>; EOC Report (CDC)

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Subject: CDC Returning Traveler Discussion for F11 Jurisdictions

When: Monday, February 10, 2020 3:00 PM-4:00 PM.

Where: Bridgeline: 1(888)455-7719 Passcode: [REDACTED] or Bldg. 21 3rd Floor 3025B

CDC Returning Traveler Discussion for F11 Jurisdictions

CDC's 2019 Novel Coronavirus (2019-nCoV) response team will host a call from 3 p.m. to 4 p.m. EST for the duration of this week, to discuss plans for returning travelers **within the eleven funneling jurisdictions**, status reports and concerns. Feel free to include your state epidemiologist, preparedness director, state/city emergency management official, and other core team members.

Bridgeline: 1(888)455-7719

Passcode: [REDACTED]

Attached, please see attached CDC guidance which was developed for the public health departments serving the F11 locations. **We request you keep this guidance CLOSE HOLD, as the following documents are not posted on CDC's nCoV response webpage. At this time, we are only sharing these documents with F11.** Lastly, please be mindful this is interim guidance and as the response continues and we learn more guidance will be adjusted accordingly.

1. **“Interim Cleaning Recommendations Related to People with Exposures to 2019 Novel Coronavirus Under Observation while Quarantined in Non-Home Residential Settings**
- This guidance is intended to address recommended cleaning and disinfection practices for non-home residential quarantine locations, as well as associated worker protection practices according to expected job tasks.

2. **“Interim Guidance Related to the Airport Ground Transport of People Subject to Mandatory Quarantine for 2019 Novel Coronavirus Exposure”** - is intended to address recommended worker protection practices for drivers of ground transport passenger vehicles and those workers who perform routine cleaning of the vehicles.

State Coordination Task Force (SCTF)

Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention ([CDC](#))

1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

[REDACTED]

From: CDC IMS State Coordination Task Force (SCTF) Operations <eoescfops@cdc.gov <mailto:eoescfops@cdc.gov>>
Sent: Monday, February 10, 2020 9:21 AM
To: CDC IMS State Coordination Task Force (SCTF) Operations; CDC IMS State Coordination Task Force (SCTF) Lead; EOC Report (CDC); Angell, Sonia Y@CDPH; Morrow, Scott (CDC smc.gov.org); Ferrer, Barbara@LACounty; Aragon, Tomas MD, DrPH (CDC sfldph.org); Hellerstedt, John (CDC dshs.texas.gov); Phillip.huang@dallascounty.org <mailto:Phillip.huang@dallascounty.org>; vtaneja@TarrantCounty.com <mailto:vtaneja@TarrantCounty.com>; Gary.Anthone@nebraska.gov <mailto:Gary.Anthone@nebraska.gov>; Wiesman, John (CDC doh.wa.gov); patty.hayes@kingcounty.gov <mailto:patty.hayes@kingcounty.gov>; kathleen.toomey@dph.ga.gov <mailto:kathleen.toomey@dph.ga.gov>; Zucker, Howard A (HEALTH); Layton, Marci (CDC health.nyc.gov); Judith.Persichilli@doh.nj.gov <mailto:Judith.Persichilli@doh.nj.gov>; Ngozi.Ezike@illinois.gov <mailto:Ngozi.Ezike@illinois.gov>; Arwady, Allison AA (CDC cityofchicago.org); bruce.s.anderson@doh.hawaii.gov <mailto:bruce.s.anderson@doh.hawaii.gov>; norm.oliver@vdh.virginia.gov <mailto:norm.oliver@vdh.virginia.gov>; KhaldunJ@michigan.gov <mailto:KhaldunJ@michigan.gov>; Watt, James (CDC cdph.ca.gov); CSallenave@smc.gov.org <mailto:CSallenave@smc.gov.org>; Balter, Sharon (CDC ph.lacounty.gov); juliet.stoltey@sfdph.org <mailto:juliet.stoltey@sfdph.org>; Gaul, Linda (CDC dshs.state.tx.us); Wendy.Chung@dallascounty.org <mailto:Wendy.Chung@dallascounty.org>; Jones, Russ (CDC tarrantcounty.com); Safranek, Thomas <NE> (CDC nebraska.gov); Lindquist, Scott SL (CDC doh.wa.gov); Duchin, Jeff (CDC kingcounty.gov); Drenzek, Cherie (CDC dph.ga.gov); Blog, Debra S (HEALTH); Tan, Christina CT (CDC doh.nj.gov); Layden, Jennifer (CDC illinois.gov); sarah.murray@cityofchicago.org <mailto:sarah.murray@cityofchicago.org>; sarah.park@doh.hawaii.gov <mailto:sarah.park@doh.hawaii.gov>; lilian.peake@vdh.virginia.gov <mailto:lilian.peake@vdh.virginia.gov>; Lyoncallos@michigan.gov <mailto:Lyoncallos@michigan.gov>; Hawkins, Eric (CDC isdh.in.gov); McCormick, Dave (CDC isdh.in.gov); Susan Fanelli; tricia.Blocher@cdph.ca.gov <mailto:tricia.Blocher@cdph.ca.gov>; Stella Fogleman; jeff.hoogheem@dshs.state.tx.us <mailto:jeff.hoogheem@dshs.state.tx.us>; Michelle.Petriatis@dshs.texas.gov <mailto:Michelle.Petriatis@dshs.texas.gov>; Halvorson, Clark (CDC doh.wa.gov); Minarcine, Scott; Primeau, Michael J (HEALTH); HURST, PHILLIP (TROOPERS); bmalin@health.nyc.gov <mailto:bmalin@health.nyc.gov>; Dana.johnson@doh.nj.gov <mailto:Dana.johnson@doh.nj.gov>; Keturah.Tracy@illinois.gov <mailto:Keturah.Tracy@illinois.gov>; Winfred.Rawls@illinois.gov <mailto:Winfred.Rawls@illinois.gov>; Christopher Shields; judy.kern@doh.hawaii.gov <mailto:judy.kern@doh.hawaii.gov>; tsantos@honolulu.gov <mailto:tsantos@honolulu.gov>; bob.mauskapf@vdh.virginia.gov <mailto:bob.mauskapf@vdh.virginia.gov>; macqueenm@michigan.gov <mailto:macqueenm@michigan.gov>; Scott, Linda (DHHS); mlytle@isdh.in.gov <mailto:mlytle@isdh.in.gov>; dutyofficer@cdph.ca.gov <mailto:dutyofficer@cdph.ca.gov>; asambol@unmc.edu <mailto:asambol@unmc.edu>; brian.hiatt@doh.wa.gov <mailto:brian.hiatt@doh.wa.gov>; Harjinder.Ghuman@dph.ga.gov <mailto:Harjinder.Ghuman@dph.ga.gov>; St. George, Kirsten (HEALTH); Rakeman, Jennifer JR (CDC health.nyc.gov); thomas.kirn@doh.nj.gov <mailto:thomas.kirn@doh.nj.gov>; matt.charles@illinois.gov <mailto:matt.charles@illinois.gov>; Pacilli, Massimo (CDC cityofchicago.org); remedios.gose@doh.hawaii.gov <mailto:remedios.gose@doh.hawaii.gov>; latoya.griffin-thomas@dgs.virginia.gov <mailto:latoya.griffin-thomas@dgs.virginia.gov>; shahs@michigan.gov <mailto:shahs@michigan.gov>; mglazier@isdh.in.gov <mailto:mglazier@isdh.in.gov>; Hutton, Brad J (HEALTH); kbox@isdh.in.gov <mailto:kbox@isdh.in.gov>; Cohen, Nicole (Nicky) (CDC/DDID/NCEZID/DGMQ); Weber, Angela (CDC/NIOSH/OD)
Subject: CDC Returning Traveler Discussion for F11 Jurisdictions
When: Occurs every day effective 2/10/2020 until 2/14/2020 from 3:00 PM to 4:00 PM Eastern Standard Time.
Where: Bridgeline: 1(888)455-7719 Passcode: [REDACTED] OR Bldg. 21 5th Fl., 5116

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CDC Returning Traveler Discussion for F11 Jurisdictions

CDC's 2019 Novel Coronavirus (2019-nCoV) response team will host a call from 3 p.m. to 4 p.m. EST for the duration of this week, to discuss plans for returning travelers within the eleven funneling jurisdictions, status reports and concerns. Feel free to include your state epidemiologist, preparedness director, state/city emergency management official, and other core team members.

Bridgeline: 1(888)455-7719

Passcode: [REDACTED]

From: [Centers for Disease Control and Prevention](#)
To: [Dreslin, Sally R \(HEALTH\)](#)
Subject: CDC COCA Now: MMWR Early Release Initial Public Health Response and Interim Clinical Guidance for the 2019 Novel Coronavirus Outbreak and Persons Evaluated for 2019 Novel Coronavirus
Date: Saturday, February 8, 2020 9:28:31 PM

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MMWR Updates: Initial Public Health Response and Interim Clinical Guidance for the 2019 Novel Coronavirus Outbreak; and Persons Evaluated for 2019 Novel Coronavirus — United States, January 2020

Dear COCA Partners and Subscribers, we would like to notify you of two recently released *Morbidity and Mortality Weekly Reports (MMWRs)* about novel coronavirus (2019-nCoV).

The first report, [Initial Public Health Response and Interim Clinical Guidance for the 2019 Novel Coronavirus Outbreak — United States, December 31, 2019–February 4, 2020](#) (*MMWR Weekly/February 7, 2020. On February 5, 2020, this report was posted online as an MMWR Early Release.*), describes 9 of the first 11 U.S. 2019-nCoV patients who were exposed in Wuhan, China. CDC expects more U.S. cases and is collaborating with multiple other federal agencies, state and local health departments, and other partners to implement aggressive measures to substantially slow U.S. transmission of 2019-nCoV, including identifying U.S. cases and contacts and managing travelers arriving from mainland China to the United States. Interim guidance is available at <https://www.cdc.gov/coronavirus/index.html> and will be updated as more information becomes available.

The second report, [Persons Evaluated for 2019 Novel Coronavirus — United States, January 2020](#), takes an in-depth look at how CDC responded to clinical inquiries regarding approximately 650 persons in the United States and tested 210 for 2019-nCoV, one fifth of whom reported no recent travel-related risk but had close contact with a 2019-nCoV patient or a person under investigation for 2019-nCoV in the United States. (*MMWR Early Release/February 7, 2020/69*)

The Emergency Risk Communication Branch in the Division of Emergency Operations, Center for Preparedness and Response is responsible for the management of all COCA products.

For information about this update or other clinical issues, or to send your feedback, please contact us at coca@cdc.gov

[CDC Clinician Outreach and Communication Activity Facebook page](#)—connect with COCA on Facebook

[Clinician Outreach and Communication Activity](#)—resources for healthcare providers

[COCA RSS Feed](#)—subscribe to be notified of conference calls, updates, and CDC guidance for health providers

[Crisis & Emergency Risk Communication Training](#)—training program that draws from lessons learned during public health emergencies, and incorporates best practices from the fields of risk and crisis communication

[Health Alert Network](#)—CDC's primary method of sharing cleared information about urgent public health incidents with public information officers; federal, state, territorial, and local public health practitioners; clinicians; and public health laboratories



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Centers for Disease Control and Prevention

1600 Clifton Rd Atlanta, GA 30329 1-800-CDC-INFO (800-232-4636) TTY: 888-232-6348

[Questions or Problems](#) | [Unsubscribe](#)

From: [Centers for Disease Control and Prevention](#)
To: [Dreslin, Sally R \(HEALTH\)](#)
Subject: CDC COCA Now: Shipping of CDC 2019 Novel Coronavirus Diagnostic Test Kits Begins
Date: Thursday, February 6, 2020 4:26:57 PM

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Shipping of CDC 2019 Novel Coronavirus Diagnostic Test Kits Begins

Distribution of CDC Diagnostic Test Kits Will Expand Laboratory Capacity to Detect 2019-nCoV

A CDC-developed laboratory test kit to detect 2019 novel coronavirus (2019-

nCoV) began shipping on February 6, 2020, to select qualified U.S. and international laboratories. Distribution of the tests will help improve the global capacity to detect and respond to the 2019 novel coronavirus.

The test kit, called the Centers for Disease Control and Prevention (CDC) 2019-Novel Coronavirus (2019-nCoV) Real-Time Reverse Transcriptase (RT)-PCR Diagnostic Panel (CDC 2019-nCoV Real Time RT-PCR), is designed for use with an existing RT-PCR testing instrument that is commonly used to test for seasonal influenza.

The CDC 2019 novel coronavirus test is intended for use with upper and lower respiratory specimens collected from people who meet [CDC criteria for 2019-nCoV testing](#). The test uses a technology that can provide results in four hours from initial sample processing to result.

The test kit has not been FDA cleared or approved, however, distribution and use of the test kits follow the [U.S. Food and Drug Administration \(FDA\) February 4, 2020, issuance of an Emergency Use Authorization \(EUA\)](#). The tests are being shipped through the [International Reagent Resource \(IRR\)](#), a CDC-established mechanism that distributes laboratory reagents domestically and globally.

Initially, about 200 test kits will be distributed to U.S. domestic laboratories and a similar amount will be distributed to select international laboratories. Each test kit can test approximately 700 to 800 patient specimens. Additional test kits will be produced and made available for ordering in the future from the IRR. At this time, each laboratory that places an order will receive one 2019-nCoV test kit.

The IRR is accepting orders for 2019-nCoV tests from qualified laboratories. This includes 115 qualified U.S. laboratories, such as state and local public health laboratories and Department of Defense (DoD) laboratories, as well as 191 qualified international laboratories, such as the World Health Organization (WHO) Global Influenza Surveillance Response System (GISRS) laboratories.

This test is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of in vitro diagnostic tests for detection and/or diagnosis of 2019-nCoV under Section 564(b)(1) of the Act, 21 U.S.C. 360bbb-3(b)(1), unless the authorization is terminated or revoked sooner.

Check the [CDC 2019 Novel Coronavirus Website](#) for the latest information and guidance on 2019-nCoV. The CDC will continue to update its guidance as the 2019-nCoV situation evolves.

Read the entire [CDC Press Release](#) for more information.

###

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

CDC works 24/7 protecting America's health, safety, and security. Whether diseases start at home or abroad, are curable or preventable, chronic or acute, or from human activity or deliberate attack, CDC responds to America's most pressing health threats. CDC is headquartered in Atlanta and has experts located throughout the United States and the world.

The Emergency Risk Communication Branch in the Division of Emergency Operations, Center for Preparedness and Response is responsible for the management of all COCA products.

For information about this update or other clinical issues, or to send your feedback, please contact us at coca@cdc.gov

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[Clinician Outreach and Communication Activity](#)—resources for healthcare providers

[COCA RSS Feed](#)—subscribe to be notified of conference calls, updates, and CDC guidance for health providers

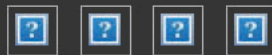
[Crisis & Emergency Risk Communication Training](#)—training program that draws from lessons learned during public health emergencies, and incorporates best practices from the fields of risk and crisis communication

[Health Alert Network](#)—CDC's primary method of sharing cleared information about urgent public health incidents with public information officers; federal, state, territorial, and local public health practitioners; clinicians; and public health laboratories



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From: Zucker, Howard A (HEALTH) <howard.zucker@health.ny.gov>

Sent: Thursday, February 6, 2020 2:21:42 PM

To: Cetron, Marty (CDC/DDID/NCEZID/DGMQ) <mzc4@cdc.gov>

Subject: <no subject>

Hi Marty,

I know you must be juggling so many things at one time. Up here in NY we are doing everything we can to help out. Can I ask that you make sure that NY State is on any calls that CDC has with EOC regarding coronavirus in NY. Apparently there have been at least a half dozen calls with NYC DOHMH and at times with NJ DOH that we have been left off. Just trying to avoid duplication of our efforts. Thank you very much.

Speak soon and let me know if you need anything!

Howard

From: [CDC IMS 2019 NCOV Response PUI](#)
To: [Ann Winters](#); [Demetre Daskalakis](#); [Layton, Marci](#) (CDC health.nyc.gov); [Rakeman, Jennifer JR](#) (CDC health.nyc.gov); [Zucker, Howard A](#) (HEALTH); [Hutton, Brad J](#) (HEALTH); [Dreslin, Sally R](#) (HEALTH); [Blog, Debra S](#) (HEALTH); [Kuhles, Daniel J](#) (HEALTH); [bryron.backenson@health.ny.gov](#)
Cc: [CDC IMS 2019 NCOV Response PUI](#); [CDC IMS Logistics Transportation](#); [Hyde, Allen W.](#) (CDC/DDPHSIS/CPR/DEO); [Schneider, Eileen](#) (CDC/DDID/NCIRD/DVD)
Subject: PUI 0320NY
Date: Wednesday, February 5, 2020 9:26:59 AM
Attachments: [CDC RVDP Specimen Submission Guidelines v7.0.pdf](#)
[DASH form-50-34.pdf](#)
[pui-form Update 1Feb20.pdf](#)

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Hello:

Thank you for contacting CDC about the patient under investigation (PUI) for novel coronavirus. Please find summary information below to help assist in the PUI evaluation and specimen referral.

Summary

24 yo male Chinese grad student in NY returned from Hubei on 1/27; transited through Wuhan for about 24 hours in early January; stayed in Huangshi in Hubei Province. No known ill contacts. On 2/1, developed cough, SOB and subjective fever. Seen in ED: afebrile; Biofire negative; discharged from ED. Grad student, stays in private housing, not in dorm/aggregate housing.

CDC nCoV ID: 0320NY

POC Details

Name: Anne Winters
Location: NYC DOHMH
Phone: 347-396-2614
Email: awinters@health.nyc.gov

Additional information

Guidance for health departments to submit PUI information to CDC can be found [here](#). Include the CDC nCoV ID issued to you by CDC in the top right box and on all specimen forms. The PUI form should be submitted as soon as able and need not wait for specimen shipping. Instructions on how to submit the PUI form are located at the top of the form.

Laboratory testing: At this time, CDC requests referral of NP swab (VTM) and OP swab (VTM) specimens. A sputum (sterile container) specimen should also be sent if a productive cough is present. The NP and OP swabs should be placed in separate VTM vials. Serum specimens are not needed at this time for PUI testing.

Specimens should be packed according to International Air Transport Association (IATA) regulations. Shipments from outside of the United States may require an importation permit that can be obtained from the CDC. For specific instructions, see the "Packing, Shipping, and

Transport” section from this CDC [website](#).

Please see the attached *2019 Novel Coronavirus (nCoV) Specimen Submission Guidelines* for detailed guidance on specimen shipment, packaging, and documentation.

Precautions: For healthcare personnel, we recommend the following guidance: <https://www.cdc.gov/coronavirus/2019-nCoV/infection-control.html> If the PUI seeks healthcare, CDC recommends they alert providers in advance for adequate infection control preparations.

If the PUI is under home care, please consider the following CDC guidance: <https://www.cdc.gov/coronavirus/2019-ncov/guidance-home-care.html>

Please let us know if you have any additional questions or concerns. For urgent inquiries, please contact the CDC Emergency Operations Center at 770-488-7100.

Thank you,

CDC IMS 2019 NCOV Response PUI Team
2019 Novel Coronavirus Response
eocevent185@cdc.gov

CDC RESPIRATORY VIRUSES DIAGNOSTIC LABORATORY

2019 NOVEL CORONAVIRUS (nCoV) SPECIMEN SUBMISSION GUIDELINES

The Respiratory Viruses Diagnostic Laboratory, located within Division of Viral Diseases, Centers for Disease Control and Prevention (CDC), is responsible for the detection and identification of respiratory viruses (non-influenza), including respiratory syncytial virus, human parainfluenza viruses 1-4, human metapneumovirus, adenovirus, rhinovirus, coronavirus (including SARS-coronavirus and MERS) and human bocavirus. Diagnostic testing for human parvovirus B19 is also available on a limited basis.

Prior to submitting any specimens, consultation is required

SAFETY NOTE

Health care personnel collecting clinical samples from potentially infectious patients should follow infection prevention and control [recommendations](#). Sample processing should be performed in at least a Class II biological safety cabinet following a minimum of biosafety level 2 guidelines. Please refer to the CDC website for specimen handling biosafety guidelines: <https://www.cdc.gov/coronavirus/2019-nCoV/lab/index.html>

TIMING OF SPECIMEN COLLECTION

Specimens should be collected as soon as possible after onset of illness, preferably within the first 3-4 days. Although some viruses may be detected after longer time periods, the likelihood of recovering most respiratory viruses diminishes after 3-4 days.

SPECIMEN TYPE

For novel coronavirus testing, CDC is currently requesting nasopharyngeal swab and oropharyngeal swab specimens on all persons under investigation (PUI). In addition, sputum samples are requested for PUIs with productive cough. Swab specimens should be collected using only swabs with a synthetic tip (e.g., polyester, Dacron®) and an aluminum or plastic shaft. Swabs with cotton tips and wooden shafts are not recommended. Specimens collected with swabs made of calcium alginate are not acceptable.

SPECIMEN COLLECTION AND STORAGE

Specific specimen collection/handling instructions and biosafety guidelines for 2019 novel coronavirus specimens are available at: <https://www.cdc.gov/coronavirus/2019-nCoV/guidance-laboratories.html>.

Refrigerate all specimens promptly after collection. If specimens can be shipped to CDC within 72 hours of collection, they should be kept refrigerated at 4°C and shipped on gel ice-packs. Freezing should be avoided if possible, as this will reduce virus viability. If specimens must be held for >72 hours, they should be promptly frozen at -70°C and shipped on dry ice. Liquid specimens should be aliquoted into properly labeled, leakproof, unbreakable screw-cap vials. Samples should be collected and processed in a manner that prevents cross-contamination between specimens, including changing gloves between specimens.

SPECIMEN LABELING AND DOCUMENTATION

All specimens must be labeled with:

- A unique identifier assigned to the patient
- CDC nCoV ID (previously called the CDC PUI ID)
- Specimen type
- Date collected

Please submit all specimens through the State Public Health Laboratory. All results will be reported from the Respiratory Viruses Diagnostic Laboratory to the State Public Health Laboratory.

FORM:

Each specimen should be accompanied by a completed CDC Form 50.34 (also known as a DASH form). Please include the 50.34 in the package and email a copy to the novel Coronavirus PUI Team Inbox (eocevent185@cdc.gov).

SHIPPING GUIDELINES

Specimens should be packed according to International Air Transport Association (IATA) regulations <http://www.iata.org/whatwedo/cargo/dgr/Pages/index.aspx>. Shipments from outside of the United States may require an importation permit that can be obtained from the CDC. For specific instructions, see the "Packing, Shipping, and Transport" section from this CDC webpage document (last section): <http://www.cdc.gov/coronavirus/mers/guidelines-lab-biosafety.html>

Specimens should be stored and shipped at the temperatures indicated in the *Specimen Collection and Storage* section above. **If samples are unable to be shipped within 72 hours of collection, they should be stored at -70°C and shipped on dry ice.** Virus isolates can be shipped on gel ice-packs. When shipping a frozen specimen from long distances or from international locations, it is best to use a combination of dry ice and frozen gel ice-packs. The gel ice-packs will remain frozen for a day or two after the dry ice has dissipated.

All specimens must be prepacked to prevent breakage and spillage.

- Specimen containers should be sealed with Parafilm® and placed in ziplock bags.
- Place enough absorbent material to absorb the entire contents of the Secondary Container (containing Primary Container) and separate the Primary Containers (containing specimen) to prevent breakage.
- Send specimens with cold packs or other refrigerant blocks that are self-contained, not actual wet ice. This prevents leaking and the appearance of a spill.
- When large numbers of specimens are being shipped, they should be organized in a sequential manner in boxes with separate compartments for each specimen.

Some things **not to do**:

- Do not place any dry ice in the "Primary Container" or "Secondary Container", foam envelopes, ziplock bags, cryovial boxes, or hermetically sealed containers.
- Do not place Primary Containers sideways or upside down in ziplock bags.
- Do not place any paperwork in the Secondary Containers or ziplock bags, so as not to damage the paperwork.
- Do not use biohazard/autoclave bags to prepack your materials due the inadequate seal of these bags.

When shipments are going out on Monday – Thursday:

Ship overnight using your usual courier such as FedEx or UPS to the following address

ATTN: STAT LAB

c/o Steve Lindstrom, Shifaq Kamili (Unit 84)

Respiratory Viruses Diagnostic Laboratory / DVD

Centers for Disease Control and Prevention

1600 Clifton Road, NE

Atlanta, Georgia, 30333

Telephone: 404-639-1587

Email: SQL5@CDC.GOV

If shipments are going out Friday, Saturday, or Sunday or holidays:

- The designated shipping point of contact should collect the following information:
 - Name and contact information for the person who will be handing the package to the courier
 - Address of where the package will be picked up
 - Estimated time the package will be ready
 - Number, rough dimensions, and rough weight of the package(s)
 - Whether package contains cold pack, dry ice, or other
 - PUI ID

- Next, the shipping point of contact should email the above information to CDC IMS Logistics Transportation (eocevent306@cdc.gov) and CDC IMS Logistics Section Chief (CDC) (eoclogchief@cdc.gov)
- Then the shipping point of contact should call the CDC Emergency Operations Center (770-488-7100) to arrange weekend-specific overnight specimen logistics. Please indicate that the call is about coronavirus specimen shipping and please have the PUI ID number.
- CDC EOC shipping staff will contact the person handing off the package to provide the details for how and when the courier will pick up the package.

Please email the CDC laboratory staff (sgk5@cdc.gov), the Novel Coronavirus Response Laboratory Task Force (eocevent177@cdc.gov), and the Novel Coronavirus Response PUI Team (eocevent185@cdc.gov) the shipping information, including the sender's name on the shipping label and the tracking number.

If testing for the 2019 novel coronavirus is requested, please add "2019 novel coronavirus" to the ATTN: line in the shipping address.

Version 6.0, February 2, 2020



Interim 2019 novel coronavirus (2019-nCoV) patient under investigation (PUI) form

As soon as possible, notify and send completed form to: 1) your local/state health department, and 2)) CDC: email (eoevent185@cdc.gov, subject line: nCoV PUI Form) or fax (770-488-7107). If you have questions, contact the CDC Emergency Operations Center (EOC) at 770-488-7100.

Today's date _____ State patient ID _____ NNDSS local record ID/Case ID¹ _____ State _____ County _____

Patient first name _____ Patient last name _____ Patient date of birth _____

Interviewer's name _____ Phone _____ Email _____

Physician's name _____ Phone _____ Pager or Email _____

Sex ☐ M ☐ F Age _____ yr ☐ mo Residency ☐ US resident ☐ Non-US resident, country _____ PUI

Criteria

Date of symptom onset _____

Does the patient have the following signs and symptoms (check all that apply)?

☐ Fever² ☐ Cough ☐ Sore throat ☐ Shortness of breath

Does the patient have these additional signs and symptoms (check all that apply)?

☐ Chills ☐ Headache ☐ Muscle aches ☐ Vomiting ☐ Abdominal pain ☐ Diarrhea ☐ Other, Specify _____

In the 14 days before symptom onset, did the patient:

Spend time in China?	☐ Y ☐ N ☐ Unknown
Does the patient live in China?	☐ Y ☐ N ☐ Unknown
Date traveled to China _____ Date traveled from China _____ Date arrived in US _____	

Spend time in Wuhan City, China?	☐ Y ☐ N ☐ Unknown
Does the patient live in Wuhan City?	☐ Y ☐ N ☐ Unknown

Spend time in Hubei Province (not Wuhan City)?	☐ Y ☐ N ☐ Unknown
Does the patient live in Hubei Province (not Wuhan City)?	☐ Y ☐ N ☐ Unknown

Spend time outside of the U.S. (not China)?	☐ Y ☐ N ☐ Unknown
Name of country _____	
Does the patient live in this country?	☐ Y ☐ N ☐ Unknown
Date traveled to country (not China) _____ Date traveled from country (not China) _____	
Date arrived in US from country (not China) _____	

Have close contact ³ with a person who is under investigation for 2019-nCoV?	☐ Y ☐ N ☐ Unknown
---	--

Have close contact ³ with a laboratory-confirmed 2019-nCoV case?	☐ Y ☐ N ☐ Unknown
Was the case ill at the time of contact?	☐ Y ☐ N ☐ Unknown
Is the case a U.S. case?	☐ Y ☐ N ☐ Unknown
Is the case an international case?	☐ Y ☐ N ☐ Unknown
In which country was the case diagnosed with 2019 n-CoV? _____	

Additional Patient Information

Is the patient a health care worker? ☐ Y ☐ N ☐ Unknown

Have history of being in a healthcare facility (as a patient, worker, or visitor) in China? ☐ Y ☐ N ☐ Unknown

Care for a nCoV patient? ☐ Y ☐ N ☐ Unknown

Is patient a member of a cluster of patients with severe acute respiratory illness (e.g., fever and pneumonia requiring hospitalization) of unknown etiology in which nCoV is being evaluated? ☐ Y ☐ N ☐ Unknown

Diagnosis (select all that apply): Pneumonia (clinical or radiologic) ☐ Y ☐ N Acute respiratory distress syndrome ☐ Y ☐ N

Comorbid conditions (check all that apply): ☐ None ☐ Unknown ☐ Pregnancy ☐ Diabetes ☐ Cardiac disease ☐ Hypertension

☐ Chronic pulmonary disease ☐ Chronic kidney disease ☐ Chronic liver disease ☐ Immunocompromised ☐ Other, specify _____

Is/was the patient: Hospitalized? ☐ Y, admit date _____ ☐ N Admitted to ICU? ☐ Y ☐ N

Intubated? ☐ Y ☐ N On ECMO? ☐ Y ☐ N Patient died? ☐ Y ☐ N

Does the patient have another diagnosis/etiology for their respiratory illness? ☐ Y, Specify _____ ☐ N ☐ Unknown

PLEASE TURN OVER

Respiratory diagnostic results

Test	Pos	Neg	Pending	Not done
Influenza rapid Ag ☐ A ☐ B	☐	☐	☐	☐
Influenza PCR ☐ A ☐ B	☐	☐	☐	☐
RSV	☐	☐	☐	☐
H. metapneumovirus	☐	☐	☐	☐
Parainfluenza (1-4)	☐	☐	☐	☐
Adenovirus	☐	☐	☐	☐
Rhinovirus/enterovirus	☐	☐	☐	☐

Specimens for 2019-nCoV testing

Specimen type	Specimen ID	Date collected	Sent to CDC?
NP swab			☐
OP swab			☐
Sputum			☐
BAL fluid			☐
Tracheal aspirate			☐

Test	Pos	Neg	Pending	Not done
Coronavirus (OC43, 229E, HKU1, NL63)	☐	☐	☐	☐
<i>M. pneumoniae</i>	☐	☐	☐	☐
<i>C. pneumoniae</i>	☐	☐	☐	☐
Other, Specify _____	☐	☐	☐	☐

Specimen type	Specimen ID	Date collected	Sent to CDC?
Stool			☐
Urine			☐
Serum			☐
Other, specify _____			☐
Other, specify _____			☐

¹ For NNDSS reporters, use GenV2 or NETSS patient identifier.² Fever may not be present in some patients, such as those who are very young, elderly, immunosuppressed, or taking certain medications. Clinical judgement should be used to guide testing of patients in such situations³ Close contact is defined as: a) being within approximately 6 feet (2 meters) or within the room or care area for a prolonged period of time (e.g., healthcare personnel, household members) while not wearing recommended personal protective equipment (i.e., gowns, gloves, respirator, eye protection); or b) having direct contact with infectious secretions (e.g., being coughed on) while not wearing recommended personal protective equipment. Data to inform the definition of close contact are limited. At this time, brief interactions, such as walking by a person, are considered low risk and do not constitute close contact.

From: [Centers for Disease Control and Prevention](#)
To: [Zucker Howard A \(HEALTH\)](#)
Subject: National Black HIV/AIDS Awareness Day
Date: Wednesday, February 5, 2020 9:11:30 AM

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February 5, 2020

Dear Colleague:

This year's [National Black HIV/AIDS Awareness Day](#) (NBHAAD) theme, *We're in This Together*, emphasizes the importance of support from friends, family, colleagues, and partners. Social support is especially important because of its potential to mitigate the negative impact of ongoing health disparities and stigma. On February 7th and every day, we can get involved in prevention efforts, get tested, get treatment if we have HIV, and use prevention tools such as pre-exposure prophylaxis (PrEP) and condoms if we do not.

Additional Resources:

Let's Stop HIV Together

<https://www.cdc.gov/stophivtogether/>

The *Let's Stop HIV Together* campaign (formerly known as Act Against AIDS) includes resources and partnerships aimed at stopping HIV stigma and promoting HIV testing, prevention, and treatment.

[Blacks](#) represent 13% of the U.S. population, yet make up 43% of new HIV diagnoses. The most recent HIV diagnoses data show decreasing disparities for some groups, but inequities remain. From 2010 to 2017, HIV diagnoses:

- decreased 15% among blacks overall;
- decreased 27% among black women;
- decreased 32% among heterosexual black men;
- were stable among [gay and bisexual black men overall](#), but varied by age.

Limited access to services, stigma, discrimination, poverty, and homophobia place some African Americans at higher risk for HIV. The poverty rate is higher among African Americans than other racial/ethnic groups, and the socioeconomic issues associated with poverty—including limited access to high-quality health care, housing, and HIV prevention education—directly and indirectly increase risk for HIV infection.

We can, and must, do better.

Goals we once thought impossible are well within reach, but eliminating racial disparities is critical. Despite the game-changing developments in HIV prevention and treatment tools, not everyone is benefiting equally from these advances. A recent CDC [report](#) showed that from 2010 to 2017, fewer blacks, compared with whites, were linked to HIV medical care within 90 days of diagnosis, retained in care, or virally suppressed.

The HHS [Ending the HIV Epidemic: A Plan for America](#) (EHE) Initiative is a bold effort to reduce new HIV infections by 90% by 2030. The initiative significantly increases resources, technology, and expertise where they're needed most—and it will decrease disparities. Phase 1 of the EHE initiative focuses on 48 counties, Washington, D.C. and San Juan, Puerto Rico, that together account for more than 50% of new U.S. HIV diagnoses, and seven states that have a substantial rural burden of HIV. Nearly two-thirds (62%) of new HIV diagnoses in 2017 for black/African Americans were in the 57 EHE phase 1 jurisdictions.

CDC is working on all fronts to improve access to testing, overcome barriers for linkage to and retention in care, increase access to PrEP, and reduce new infections and HIV-related disparities. For example, CDC is focused on using the latest systems and technology to make testing truly routine in healthcare facilities that are likely to engage people at risk for HIV who otherwise have limited access to healthcare. CDC is working with grantees, partners and providers to ensure immediate—ideally same-day—linkage to care for people with a new diagnosis of HIV and linkage to PrEP services for those at risk but who do not have HIV. And to help increase PrEP uptake, HHS has launched [Ready, Set, PrEP](#), a nationwide program that makes PrEP medications available at no cost to individuals who qualify and lack prescription drug coverage. Eligibility requirements and an explanation of how the program works are available at [GetYourPrEP.com](#) and 1-855-447-8410.

This year's theme, *We're in This Together*, emphasizes the

CDC HIV/AIDS

www.cdc.gov/hiv

Visit CDC's HIV/AIDS Web site.

CDC-INFO

1-800-CDC-INFO

(232-4636)

Get information about personal risk, prevention, and testing.

CDC National HIV Testing Resources

GetTested.cdc.gov

Text your ZIP code to KNOW IT or 566948. Locate an HIV testing site near you.

CDC National Prevention Information Network (NPIN)

npin.cdc.gov

Find CDC resources and technical assistance.

AIDSinfo

1-800-448-0440

www.aidsinfo.nih.gov

Locate resources on HIV and AIDS treatment and clinical trials.

Please [contact us](#) with questions, comments or other feedback about e-HAP

importance of social support—from friends, family, colleagues, and partners. We call on everyone to use our [digital toolkit](#) with resources from CDC's *Let's Stop HIV Together* campaign to combat HIV-related stigma and end the HIV epidemic in America. We encourage you to create and share social media content using the #StopHIVTogether and #NBHAAD hashtags. Each of us has a role to play:

Healthcare providers can

- Routinely screen all patients.
- Provide [HIV treatment](#) as soon as possible after diagnosis.
- [Prescribe PrEP](#) using CDC's guidelines.

Health departments can

- [Expand HIV testing](#) to include testing at home and other nonclinical settings.
- Strengthen HIV care and [peer support networks](#) to improve HIV treatment.
- [Increase PrEP usage](#) in communities that need it the most.

Everyone can

- [Get tested for HIV, STDs and hepatitis.](#)
- Use the [HIV Risk Reduction Tool](#) to better understand HIV.
- Talk with healthcare providers about [HIV prevention](#), including condoms and PrEP.
- Encourage friends and loved ones to stay healthy by taking medicine if they [have HIV](#) or are [on PrEP](#).

CDC is committed to ending the HIV epidemic in the United States for everyone. On this day and every day, we ask that you join us by fighting HIV-related stigma and promoting HIV testing, prevention, and treatment. It has been a long road and we have come so far. We know we can reach our goals because, as a nation, we are in this together.

Sincerely,

/Eugene McCray/
Eugene McCray, MD
Director
Division of HIV/AIDS Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB
Prevention
Centers for Disease Control and Prevention

/Jonathan Mermin/
Jonathan H. Mermin, MD, MPH
Rear Admiral and Assistant Surgeon General, USPHS
Director
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB
Prevention
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Centers for Disease Control and Prevention

1600 Clifton Rd Atlanta GA 30329 1-800-CDC-INFO (800-232-4636) TTY: 888-232-6348



From: CDC IMS State Coordination Task Force (SCTF) Operations

Sent: Tuesday, February 4, 2020 9:33 AM

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Subject: CDC Returning Traveler Discussion

When: Tuesday, February 4, 2020 3:00 PM-4:00 PM.

Where: Bridgeline: 1(888) 995-9728 Passcode: [REDACTED] OR Plans Team Room

CDC Returning Traveler Discussion

CDC's 2019 Novel Coronavirus (2019-nCoV) response team will host a call from 3 p.m. to 4 p.m. EST on Tuesday, February 4 , to discuss plans for returning travelers within the eleven funneling jurisdictions, status reports and concerns. Feel free to include your state epidemiologist, preparedness director, state/city emergency management official, and other core team members.

Bridgeline: 1(888)995-9728 Passcode: [REDACTED]

From: [Jenkins, Dawn M \(OIG/OAS\)](#)
To: [Zucker, Howard A \(HEALTH\)](#)
Cc: [doh.sm.DEA-WEBMAIL](#); [doh.sm.DOH.Audit.Unit](#); [Conway, Lori A \(HEALTH\)](#); [Silvia, Jacki S \(HEALTH\)](#); [Jessica.Lynch@health.ny.gov](#)
Subject: Official Correspondence - Report from U.S. Department of Health and Human Services, Office of Inspector General (Report Number A-XX-XX-XXXXX)
Date: Tuesday, February 4, 2020 9:56:21 AM
Attachments: [A021701021FNLRPT.pdf](#)

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Good Morning Dr. Zucker:

Attached is the Office of Inspector General final report entitled New York Claimed Tens of Millions of Dollars for Opioid Treatment Program Services That Did Not Comply With Medicaid Requirements Intended To Ensure the Quality of Care Provided to Beneficiaries, (Report Number A-02-17-01021). The report will be available to the public at <http://oig.hhs.gov>.

If you have any questions or comments about the attached report, please do not hesitate to contact Glenn H. Richter, Assistant Regional Inspector General for Audit Services, at Glenn.Richter@oig.hhs.gov. To facilitate identification, please refer to the report number in all correspondence.

If you have trouble opening the attached report and need this email resent, please contact the staff listed below.

Dawn M. Jenkins
Program Support Specialist
Department of Health and Human Services
Office of Inspector General
Office of Audit Services
dawn.jenkins@oig.hhs.gov
212-264-4620

Attachments – as stated

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL



OFFICE OF AUDIT SERVICES, REGION II
JACOB K. JAVITS FEDERAL BUILDING
26 FEDERAL PLAZA, ROOM 3900
NEW YORK, NY 10278

February 4, 2020

Report Number: A-02-17-01021

Howard A. Zucker, M.D., J.D.
Commissioner
New York State Department of Health
14th Floor, Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Zucker:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report *New York Claimed Tens of Millions of Dollars for Opioid Treatment Program Services That Did Not Comply With Medicaid Requirements Intended To Ensure the Quality of Care Provided to Beneficiaries*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary. The HHS action official will make final determination as to actions taken on all matters reported.

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG website. Accordingly, this report will be posted at <https://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Glenn H. Richter, Assistant Regional Inspector General for Audit Services, at Glenn.Richter@oig.hhs.gov. Please refer to report number A-02-17-01021 in all correspondence.

Sincerely,

Brenda M. Tierney
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Jackie Glaze
Acting Director, Regional Operations Group
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW YORK CLAIMED TENS OF MILLIONS OF DOLLARS FOR OPIOID TREATMENT PROGRAM SERVICES THAT DID NOT COMPLY WITH MEDICAID REQUIREMENTS INTENDED TO ENSURE THE QUALITY OF CARE PROVIDED TO BENEFICIARIES

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Christi A. Grimm
Principal Deputy Inspector General

February 2020
A-02-17-01021

Office of Inspector General

<https://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

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The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

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at <https://oig.hhs.gov>

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG website.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

Date: February 2020

Report No. A-02-17-01021

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

The United States currently faces a nationwide public health emergency due to the opioid crisis. Opioid treatment programs (OTPs) provide medication-assisted treatment coupled with counseling and behavioral therapies for people diagnosed with an opioid use disorder. This audit is part of the OIG's oversight of the integrity and proper stewardship of Federal funds used to combat the opioid crisis.

Our objective was to determine whether New York claimed Medicaid reimbursement for OTP services provided in the New York City metropolitan area in accordance with Federal and State requirements.

How OIG Did This Audit

Our audit covered more than 10.7 million Medicaid claims for OTP services, totaling over \$445 million (\$272 million Federal share), provided in the New York City metropolitan area during calendar years 2014 through 2017.

We reviewed a stratified random sample of 150 claims to determine compliance with Federal and State requirements. We also identified 6,700 potentially duplicate claims totaling \$267,000 (\$160,000 Federal share) from the 10.7 million claims and selected a nonstatistical sample of 598 claims to determine compliance with Federal and State requirements.

New York Claimed Tens of Millions of Dollars for Opioid Treatment Program Services That Did Not Comply With Medicaid Requirements Intended To Ensure the Quality of Care Provided to Beneficiaries

What OIG Found

New York claimed Federal Medicaid reimbursement for OTP services that did not comply with Federal and State requirements. Of the 150 claims in our random sample, 115 claims complied with Medicaid requirements, but 35 claims did not. In addition, of the 598 claims in our nonstatistical sample, 299 claims totaling \$8,905 (\$5,830 Federal share) were billed in error. Specifically, 220 claims were duplicate claims, and 79 claims were for services that the providers stated were not provided. On the basis of our sample results, we estimated that New York improperly claimed at least \$39.3 million in Federal Medicaid reimbursement for OTP services during our audit period.

These improper claims occurred because providers (1) failed to maintain or provide documentation of OTP services, (2) did not ensure that OTP services were provided in accordance with beneficiaries' treatment plans, and (3) did not maintain signatures for OTP services. Further, although New York inspects providers to verify compliance with Federal and State Medicaid requirements, it did not ensure that its oversight prevented the errors identified by our audit.

What OIG Recommends and New York State's Comments

We recommended that New York (1) refund \$39.3 million to the Federal Government, (2) ensure that providers comply with Federal and State requirements for providing and claiming reimbursement for OTP services, and (3) implement procedures to detect and prevent duplicate claims for OTP services.

In written comments on our draft report, New York did not indicate concurrence or nonconcurrence with our recommendations; however, it described actions it planned to take to address them. Specifically, New York stated that its Office of the Medicaid Inspector General will review the claims identified in our draft report as not having complied with Medicaid requirements and determine an appropriate course of action. New York also stated that it would issue guidance to OTP providers reminding them of their obligations to comply with Federal and State laws for providing and claiming Medicaid reimbursement for OTP services. Finally, New York stated that it would investigate whether edits to its Medicaid claims processing system will be required to detect and prevent duplicate claims for OTP services.

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INTRODUCTION

WHY WE DID THIS AUDIT

The United States currently faces a nationwide public health emergency due to the opioid crisis. The high potential for misuse of opioids has led to alarming trends across the country, including record numbers of people developing opioid use disorders. In 2017 alone, there were 47,600 opioid-related overdose deaths in the United States. Opioid treatment programs (OTPs) provide medication-assisted treatment coupled with counseling and behavioral therapies (referred to in this report as “OTP services”) for people diagnosed with an opioid use disorder. As part of the Office of Inspector General’s (OIG’s) oversight of the integrity and proper stewardship of Federal funds used to combat the opioid crisis, we audited OTPs located in the New York City metropolitan area.¹

OBJECTIVE

Our objective was to determine whether the New York State Department of Health (State agency) claimed Medicaid reimbursement for OTP services provided in the New York City metropolitan area in accordance with Federal and State requirements.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

New York’s Opioid Treatment Programs

In New York, the State agency administers the Medicaid program and provides Medicaid reimbursement to OTP providers (providers) certified by the New York State Office of Alcoholism and Substance Abuse Services (OASAS). OASAS inspects providers at least once every 3 years to assess compliance with Federal and State requirements when OASAS re-certifies the providers.²

¹ Specifically, we audited OTP services provided in New York City (Bronx, Kings, New York, Queens, and Richmond Counties), Long Island (Nassau and Suffolk Counties), Westchester County, and Rockland County.

² Title 14 §§ 810.14(c) and 810.14(k) of the New York Compilation of Codes, Rules, and Regulations (NYCRR).

OASAS-certified providers administer OTP services for beneficiaries diagnosed with an opioid use disorder. A beneficiary may receive OTP services at either a freestanding or a hospital-based outpatient clinic. Before treating a beneficiary, providers are required to verify with OASAS's opioid treatment access and dosage registry (central registry) that the beneficiary is not enrolled in another OTP and document the verification. Federal regulations generally limit access to enrollment information contained in the central registry to providers and solely to prevent beneficiary enrollment in multiple OTPs.³ Therefore, OASAS and the State agency do not have access to the central registry.

HOW WE CONDUCTED THIS AUDIT

We limited our audit to Medicaid claims for OTP services provided in the New York City metropolitan area from January 1, 2014, through December 31, 2017 (audit period). During this period, 35 providers submitted 10,754,849 claims and received Medicaid reimbursement totaling \$445,463,540 (\$271,790,254 Federal share). We selected a stratified random sample of 150 claims to determine compliance with Federal and State requirements. We also identified 6,700 potentially duplicate claims totaling \$267,083 (\$159,827 Federal share) from the 10,754,849 claims and selected a nonstatistical sample of 598 claims to determine compliance with Federal and State requirements.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, Appendix C contains our sample results and estimates, and Appendix D contains a list of related OIG reports.

FINDINGS

The State agency claimed Federal Medicaid reimbursement for some OTP services that did not comply with Federal and State requirements. Of the 150 claims in our sample, 115 claims complied with Medicaid requirements, but 35 claims did not. Table 1 (on the next page) summarizes the deficiencies we noted and the number of claims that contained each type of deficiency.

³ 42 CFR § 2.34(b).

Table 1: Summary of Deficiencies in Sampled Claims

Deficiency	Number of Unallowable Claims⁴
Central registry verifications not adequately documented	18
Diagnosis of opioid addiction not documented	8
Medical records not signed	5
Services not documented or supported	4
Treatment plans missing or not reviewed	4
Toxicology tests not documented	3
Services not identified in treatment plan	1

These deficiencies occurred because providers (1) failed to maintain or provide documentation of OTP services, (2) did not ensure that OTP services were provided in accordance with beneficiaries' treatment plans, and (3) did not maintain signatures for OTP services. Further, although OASAS inspects providers to verify compliance with Federal and State requirements, the State agency did not ensure that OASAS's oversight prevented the errors identified by our audit.

On the basis of our sample results, we estimated that the State agency improperly claimed at least \$39,329,059 in Federal Medicaid reimbursement for OTP services during our audit period.⁵

In addition, of the 598 claims in our nonstatistical sample, 299 claims totaling \$8,905 (\$5,830 Federal share) were billed in error.⁶ Specifically, 220 claims were duplicate claims and 79 claims were for services that the providers stated were not provided. Although OASAS inspected providers to verify compliance with Federal and State requirements, the State agency did not ensure that OASAS prevented the errors we identified. Further, OASAS had not implemented procedures to prevent duplicate claims for OTP services.

⁴ The total exceeds 35 because 8 claims contained more than 1 deficiency.

⁵ To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

⁶ The amount billed in error is included in our estimate of unallowable claims; therefore, we are not recommending a separate recovery of these funds.

THE STATE AGENCY CLAIMED REIMBURSEMENT FOR UNALLOWABLE OPIOID TREATMENT PROGRAM SERVICES

Central Registry Verifications Not Adequately Documented

Providers are required to verify with the central registry that a beneficiary is not enrolled in another OTP and document the verification in the clinical records.⁷

For 18 of the 150 claims in our sample, the providers did not adequately document that they reviewed the central registry to verify that the associated beneficiary was not enrolled in another OTP.⁸ Specifically, for 15 claims, the providers did not document that they had verified that the beneficiary was not enrolled in another OTP. For the remaining three claims, the provider documented its verification; however, the documentation did not contain the date the verification was performed. Therefore, there was not adequate evidence that the verification was performed before the sampled service date. Verifying a beneficiary's enrollment status ensures that beneficiaries are not receiving unnecessary and potentially excessive OTP services for methadone or other maintenance medication administration.⁹

Diagnosis of Opioid Addiction Not Documented

Providers must ensure that beneficiaries are admitted for OTP services by qualified personnel who have determined that the beneficiaries are addicted to an opioid drug. Providers must document beneficiaries' opioid addiction or dependence, and beginning August 25, 2015, the diagnosis must be included in the beneficiaries' treatment plans.¹⁰

For 8 of the 150 claims in our sample, the providers did not document that the associated beneficiary was diagnosed as being addicted to or dependent on an opioid drug. Specifically, for two claims with treatment plans dated before August 25, 2015, the beneficiary's *clinical*

⁷ 14 NYCRR §§ 1040.5(b)(5) and 1040.17(a)(2) (effective 1992 through July 18, 2000), 14 NYCRR § 828.7(c) (effective July 19, 2000, through June 28, 2011), 14 NYCRR § 822-5.4(c) (effective July 1, 2011, through August 24, 2015), and 14 NYCRR § 822.16(a)(3) (effective August 25, 2015). Additionally, Federal regulations state that providers must document that they made a "good faith effort" to review whether a beneficiary is enrolled in any other OTP (42 CFR § 8.12(g)(2)).

⁸ Because Federal regulations generally limit access to enrollment information contained in the central registry to providers and solely to prevent beneficiary enrollment in multiple OTPs, we were unable to verify whether the beneficiaries were enrolled in other OTPs.

⁹ Methadone is an opioid that, when taken under medical supervision, is used to treat opioid use disorder. Methadone curbs cravings and minimizes withdrawal symptoms. Addiction to methadone can develop if the drug is overprescribed, used without a prescription, or combined with other substances of abuse. Long-term use of methadone can cause nerve, liver, and brain damage.

¹⁰ 42 CFR § 8.12(e)(1), 14 NYCRR § 822-5.4(a) (effective July 1, 2011, through August 24, 2015) and 14 NYCRR §§ 822.8(d)(2) and 822.9(b)(1) (effective August 25, 2015).

record did not contain a diagnosis of an opioid addiction or dependence. For the remaining six claims with treatment plans dated on or after August 25, 2015, the *treatment plans* did not contain a diagnosis of an opioid addiction or dependence. Without documenting a diagnosis of an opioid addiction or dependence, providers cannot ensure that they are providing necessary OTP services to beneficiaries.

Medical Records Not Signed

Medical records of OTP services delivered to beneficiaries must be written and signed (physical or electronic signature) by the staff member that provided the service.¹¹ These records must be maintained in beneficiary case records for 6 years from the date the services were furnished.¹²

For 5 of the 150 claims in our sample, the providers did not maintain signed documentation for OTP services. The providers stated that they had updated or converted their software systems after the sampled service dates, and as a result, the signatures of staff members that provided the services were not retained. Without these signatures, providers cannot demonstrate that services were actually provided by qualified provider staff members.¹³

Services Not Documented or Supported

Providers must maintain medical records of OTP services in beneficiary case records for a period of 6 years from the date the services were furnished.¹⁴

For 4 of the 150 claims in our sample, the providers did not maintain documentation to support the OTP services. The providers stated that two claims were billed in error and that the providers were unable to locate the documentation to support the services for the remaining two claims. Without this documentation, providers cannot demonstrate that services were actually provided in accordance with beneficiaries' treatment plans by qualified provider staff members.

¹¹ 14 NYCRR § 822-2.5(a)(1) (effective July 1, 2011, through August 24, 2015) and 14 NYCRR § 822.11(a)(1) (effective August 25, 2015).

¹² 18 NYCRR § 504.3(a), 14 NYCRR § 822-3.1(f)(2) (effective July 1, 2011, through August 24, 2015), and 14 NYCRR § 822.6(c) (effective August 25, 2015).

¹³ 42 CFR § 8.12(h), 14 NYCRR § 822-5.9(g)(3) (effective July 1, 2011, through August 24, 2015), and 14 NYCRR § 822.7(k)(3)(iv) (effective August 25, 2015).

¹⁴ 18 NYCRR § 504.3(a), 14 NYCRR § 822-3.1(f)(2) (effective July 1, 2011, through August 24, 2015), and 14 NYCRR § 822.6(c) (effective August 25, 2015).

Treatment Plans Missing or Not Reviewed

Providers must prepare a treatment plan for each beneficiary, and the plan must be reviewed and updated. The treatment plan must be reviewed, and revised if necessary, at least every 180 calendar days after the beneficiary's first year of treatment.¹⁵ The treatment plan and all reviews and updates must be maintained in the beneficiary's case records.¹⁶

For 4 of the 150 claims in our sample, the providers did not maintain treatment plans covering the sampled service date. Specifically, for one claim, the provider stated that it was unable to locate a treatment plan covering the sampled service date. For the remaining three claims for OTP services provided after the beneficiaries' first year of treatment, the most recent treatment plans were dated more than 180 days before the sampled service dates.¹⁷ The continued review of patient-centered treatment plans is essential to ensuring that beneficiaries receive appropriate and necessary OTP services.

Toxicology Tests Not Documented

Providers must conduct at least eight random drug abuse tests per year, per beneficiary in maintenance treatment (i.e., receiving maintenance medications).¹⁸ Specifically, providers must conduct toxicology tests for the presence of benzodiazepines, cocaine, and opioids¹⁹ and include all laboratory test results in beneficiaries' records.²⁰

For 3 of the 150 claims in our sample, the providers did not document that they conducted at least 8 random toxicology tests per year on the associated beneficiaries. Specifically, for a beneficiary associated with one claim, the provider did not provide *any* toxicology test results for the 1-year period before the sampled service date. For beneficiaries associated with two other claims, the provider documented only six toxicology tests within the 1-year period before

¹⁵ 42 CFR § 8.12(f)(4), 14 NYCRR § 822-5.5(f) (effective July 1, 2011, through August 24, 2015), and 14 NYCRR § 822.9(c) (effective August 25, 2015).

¹⁶ 14 NYCRR § 822-2.2(b)(4) (effective July 1, 2011, through August 24, 2015) and 14 NYCRR § 822.10(b)(4) (effective August 25, 2015).

¹⁷ For two claims, the treatment plans did not specify the period covered by the plans. Rather, they contained the date the plans were revised, which were between 213 and 317 days before the sampled service dates. For the remaining claim, the period covered by the plan ended 94 days before the sampled service date.

¹⁸ 42 CFR § 8.12(f)(6), 14 NYCRR § 822-5.8(d) (effective July 1, 2011, through August 24, 2015), and 14 NYCRR § 822.7(g)(5)(i) (effective August 25, 2015).

¹⁹ 14 NYCRR § 822-5.8(a) (effective July 1, 2011, through August 24, 2015) and 14 NYCRR § 822.7(g)(5)(i) (effective August 25, 2015).

²⁰ 14 NYCRR § 822-2.4(a)(2) (effective July 1, 2011, through August 24, 2015) and 14 NYCRR § 822.10(c)(2) (August 25, 2015).

the sampled service date. Without conducting required toxicology tests, providers cannot verify that beneficiaries are not using illicit drugs and that their treatment plans are assessed to ensure that caution is used when providing OTP services for methadone or other maintenance medication administration.

Services Not Identified in Treatment Plan

Providers must perform an initial assessment of beneficiaries to determine the most appropriate combination of services and treatment. The assessment must include preparation of a treatment plan that identifies the medical services needed, as well as the frequency these services are to be provided.²¹

For 1 of the 150 claims in our sample, the beneficiary was administered methadone even though the treatment plan did not authorize the use of this medication. Dispensing methadone without proper medical authorization could cause serious harm to beneficiaries, as methadone doses are specifically tailored for individual beneficiaries and methadone may interact with other medications.

THE STATE AGENCY CLAIMED REIMBURSEMENT FOR DUPLICATE MEDICATION ADMINISTRATION SERVICES

New York allows more than one provider to bill for OTP services provided to a beneficiary on the same date of service. This ensures that beneficiaries seeking treatment for opioid use disorders are not denied needed services while transferring from one OTP to another. However, beneficiaries may not be *enrolled* in more than one OTP.²² In addition, providers may bill for methadone or other maintenance medication administration no more than once per day for any beneficiary.²³ Providers must also prepare and maintain service documentation for 6 years from the date the services were furnished²⁴ and document the services in the beneficiaries' case record.²⁵

²¹ 42 CFR § 8.12(f)(4), 14 NYCRR § 822-5.5(d) (effective July 1, 2011, through August 24, 2015), and 14 NYCRR § 822.9 (effective August 25, 2015).

²² 42 CFR § 8.12(g)(2), 14 NYCRR § 822-5.3(b) (effective July 1, 2011, through August 24, 2015), and 14 NYCRR § 822.16(a)(3) (effective August 25, 2015).

²³ 14 NYCRR § 822-3.1(h)(9) (effective July 1, 2011, through August 24, 2015) and 14 NYCRR § 841.14(i)(9) (effective August 25, 2015).

²⁴ 18 NYCRR § 504.3(a).

²⁵ 14 NYCRR § 822-3.1(f)(2) (effective July 1, 2011, through August 24, 2015) and 14 NYCRR § 822.6(c) (effective August 25, 2015).

For 299 of the 598 claims in our nonstatistical sample, we determined that 220 claims totaling \$6,689 (\$4,461 Federal share) were duplicate claims and 79 claims totaling \$2,216 (\$1,369 Federal share) were for services that providers stated were not provided.^{26, 27}

RECOMMENDATIONS

We recommend that the New York State Department of Health:

- refund \$39,329,059 to the Federal Government,
- ensure that providers comply with Federal and State requirements for providing and claiming reimbursement for OTP services, and
- implement procedures to detect and prevent duplicate claims for OTP services.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not indicate concurrence or nonconcurrence with our recommendations; however, it described actions it planned to take to address them. Specifically, the State agency stated that its Office of the Medicaid Inspector General will review the claims identified in our draft report as not having complied with Medicaid requirements and determine an appropriate course of action. The State agency noted that for all 8 of the 150 claims in our sample for which providers did not document that the associated beneficiary was diagnosed as being addicted to or dependent on an opioid drug, the providers documented an opioid dependence on claims submitted to the State agency. The State agency also indicated that OASAS planned to issue guidance to providers reminding them of their obligations to comply with Federal and State laws for providing and claiming Medicaid reimbursement for OTP services. Finally, the State agency stated that it planned to investigate whether edits to its Medicaid claims processing system will be required to detect and prevent duplicate claims for OTP services.

We commend the State agency for taking appropriate corrective actions in response to our recommendations. We note, however, that we did not review the effectiveness of these proposed corrective actions. Regarding the eight sample claims for which providers did not document that the associated beneficiary was diagnosed as being addicted to or dependent on an opioid drug, we maintain that our findings are valid. Specifically, documenting a diagnosis on a claim submitted to the State agency does not satisfy the Medicaid requirement that

²⁶ We did not identify any instances in which a beneficiary was administered opioid treatment medication more than one time in a day.

²⁷ The amount billed in error is included in our estimate of unallowable claims; therefore, we are not recommending a separate recovery of these funds.

providers must document beneficiaries' opioid addiction or dependence because information contained on Medicaid claims must be supported by providers' records.²⁸ Further, beginning August 25, 2015, the diagnosis must be included in the beneficiaries' treatment plans.^{29, 30}

The State agency's comments are included in their entirety as Appendix E.

²⁸ 14 NYCRR § 822-5.4(a) (effective July 1, 2011, through August 24, 2015) and 18 NYCRR § 504.3(a).

²⁹ 14 NYCRR §§ 822.8(d)(2) and 822.9(b)(1) (effective August 25, 2015).

³⁰ As indicated in the report, for two sample claims with treatment plans dated before August 25, 2015, the beneficiary's clinical record did not contain a diagnosis of an opioid addiction or dependence. For six other sample claims for which providers did not document that the associated beneficiary was diagnosed as being addicted to or dependent on an opioid drug, the associated treatment plans were dated on or after August 25, 2015. (See pages 4 and 5.)

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We limited our audit to Medicaid claims for OTP services provided in the New York City metropolitan area. During our audit period, 35 providers submitted 10,754,849 claims and received Medicaid reimbursement totaling \$445,463,540 (\$271,790,254 Federal share). We selected a stratified random sample of 150 claims to determine compliance with Federal and State requirements. We also identified 6,700 potentially duplicate claims totaling \$267,083 (\$159,827 Federal share) from the 10,754,849 claims and selected a nonstatistical sample of 598 claims to determine compliance with Federal and State requirements.

Our audit allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the Medicaid Management Information System (MMIS)³¹ for our audit period. We also established reasonable assurance of the completeness of the data by reconciling the claims' data in the MMIS with the State agency's claims for reimbursement on the Form CMS-64, Quarterly Medicaid Statement of Expenditures (CMS-64).

During our audit, we did not assess the overall internal control structure of the State agency, OASAS, or Medicaid. Rather, we reviewed only the internal controls that pertained directly to our objective.

We performed fieldwork at the State agency's and OASAS's offices in Albany, New York.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with State agency and OASAS officials to gain an understanding of the OTP program;
- obtained from New York's MMIS a sampling frame of 10,754,849 claims for OTP services provided during our audit period by New York City metropolitan area providers, totaling \$445,463,540 (\$271,790,254 Federal share);
- reconciled the claims for OTP services that the State agency claimed for Federal Medicaid reimbursement on the CMS-64 to the sampling frame of paid claims for OTP services obtained from New York's MMIS file for specific quarters within our audit period;

³¹ The MMIS is a computerized payment and information reporting system used to process and pay Medicaid claims.

- selected a stratified random sample of 150 claims from our sampling frame and, for each claim, reviewed provider and beneficiary records to determine whether the providers documented in the beneficiaries' records the following:
 - verification with the central registry that the beneficiary was not enrolled in another OTP,
 - diagnoses that the beneficiaries were addicted to or dependent on an opioid drug,
 - signed documentation supporting the services provided on the sampled service dates,
 - beneficiary treatment plans that authorized the services provided on the sampled services dates, and
 - at least eight random toxicology tests within the 1-year period before the sampled service dates;
- used computer programming to identify 6,700 potentially duplicate claims³² in our sampling frame totaling \$267,083 (\$159,827 Federal share);
- selected a nonstatistical sample of 598 claims from the potentially duplicate claims in our sampling frame, and for each claim, reviewed beneficiary records supporting the claim to determine whether the claims complied with Federal and State requirements;
- estimated the total amount of Federal Medicaid reimbursement for unallowable OTP services made to the State agency during the audit period; and
- discussed our results with State agency and OASAS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

³² We defined a potentially duplicate claim as an instance in which more than one Medicaid claim for medication administration services was billed on a single day by one or more providers for the same beneficiary.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of six Access files containing 10,754,849 claims for OTP services provided during our audit period by New York City metropolitan area providers, totaling \$445,463,540 (\$271,790,254 Federal share).³³ The Medicaid claims were extracted from the MMIS.

SAMPLE UNIT

The sample unit was an OTP claim.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample. To accomplish this, we separated the sampling frame into three strata as shown in Table 2.

Table 2: Frame Description and Sample Size

Stratum Number	Dollar Range of OTP Claims	Total Claims	Total Reimbursement	Total Federal Share	Claims Sampled
1	≤\$12.25	4,219,308	\$96,707,630	\$48,355,143	59
2	>\$12.25 and ≤\$21.255	3,569,568	94,851,291	66,028,938	50
3	>\$21.255	2,965,973	253,904,619	157,406,173	41
	Total	10,754,849	\$445,463,540	\$271,790,254	150

Note: The strata bounds were based on Federal share amounts.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services, statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in each stratum. After generating 150 random numbers following our stratified design, we selected the corresponding claims in the sampling frame for our sample.

³³ We excluded claim lines associated with a provider that was under indictment for Medicaid fraud.

ESTIMATION METHODOLOGY

We estimated the total amount of the unallowable OTP claims for which the State agency claimed reimbursement at the lower limit of the two-sided 90-percent confidence interval. We also used the statistical software to calculate the corresponding point estimate and upper limit of the two-sided 90-percent confidence interval.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 3: Sample Details and Results

Stratum Number	Total Claims	Total Federal Share	Claims Sampled	Value of Sample (Federal share)	Number of Unallowable Claims	Value of Unallowable Claims (Federal share)
1	4,219,308	\$48,355,143	59	\$677	13	\$146
2	3,569,568	66,028,938	50	929	11	215
3	2,965,973	157,406,173	41	2,613	11	413
Total	10,754,849	\$271,790,254	150	\$4,220³⁴	35	\$774

Table 4: Estimated Value of Unallowable Claims (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$55,647,993
Lower limit	39,329,059
Upper limit	71,966,927

³⁴ Differences in total calculations are due to rounding.

APPENDIX D: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>New York Achieved Program Goals for Enhancing Its Prescription Drug Monitoring Program</i>	<u>A-02-18-02001</u>	8/8/2019
<i>Oversight of Opioid Prescribing and Monitoring of Opioid Use: States Have Taken Action To Address the Opioid Epidemic</i>	<u>A-09-18-01005</u>	7/24/2019
<i>The University of Kentucky Made Progress Toward Achieving Program Goals for Enhancing Its Prescription Drug Monitoring Program</i>	<u>A-04-18-02012</u>	5/30/2019
<i>Washington State Made Progress Toward Achieving Program Goals for Enhancing Its Prescription Drug Monitoring Program</i>	<u>A-09-18-01001</u>	4/15/2019
<i>The Substance Abuse and Mental Health Services Administration Followed Grant Regulations and Program-Specific Requirements When Awarding State Targeted Response to the Opioid Crisis Grants</i>	<u>A-03-17-03302</u>	3/28/2019
<i>New York Did Not Provide Adequate Stewardship of Substance Abuse Prevention and Treatment Block Grant Funds</i>	<u>A-02-17-02009</u>	3/20/2019

APPENDIX E: STATE AGENCY COMMENTS



ANDREW M. CUOMO
Governor

Department of Health

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

December 27, 2019

Ms. Brenda Tierney
Regional Inspector General for Audit Services
Department of Health and Human Services - Region II
Jacob Javits Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No: **02-17-01021**

Dear Ms. Tierney:

Enclosed are the New York State Department of Health's comments on the United States Department of Health and Human Services, Office of Inspector General's Draft Audit Report **A-02-17-02021** entitled, "New York Claimed Tens of Millions of Dollars for Opioid Treatment Program Services That Did Not Comply With Medicaid Requirements Intended To Ensure the Quality of Care Provided to Beneficiaries."

Thank you for the opportunity to comment.

Sincerely,

A handwritten signature in black ink, appearing to read "Sally Dreslin".

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Marybeth Hefner
Diane Christensen
Elizabeth Misa
Geza Hrazdina
Dan Duffy
Jeffrey Hammond
Jill Montag
Michael Spitz
James DeMatteo
James Cataldo
OHIP Audit SM

Empire State Plaza, Corning Tower, Albany, NY 12237 | health.ny.gov

**New York State Department of Health
Comments on the Department of Health and Human Services
Office of Inspector General Draft Audit Report A-02-17-01021 entitled,
“New York Claimed Tens of Millions of Dollars for Opioid Treatment
Program Services That Did Not Comply With Medicaid Requirements
Intended To Ensure the Quality of Care Provided to Beneficiaries”**

The following are the New York State Department of Health's (Department) comments in response to the Department of Health and Human Services, Office of Inspector General (OIG) Draft Audit Report A-02-17-01021 entitled, “New York Claimed Tens of Millions of Dollars for Opioid Treatment Program Services That Did Not Comply With Medicaid Requirements Intended To Ensure the Quality of Care Provided to Beneficiaries”.

Recommendation #1:

Refund \$39,329,059 to the Federal Government.

Response #1:

As part of the Office of the Medicaid Inspector General's (OMIG) ongoing efforts in auditing Opioid Treatment Program (OTP) providers, the State has identified and refunded \$4 million to date to the Federal Government. Additional OMIG audits of 10 OTP providers are underway. OMIG has requested records and supporting documentation from the OIG to analyze the findings of this audit and, in conjunction with the Department and the Office of Addiction Services and Supports (OASAS), will determine an appropriate course of action.

Recommendation #2:

Ensure that providers comply with Federal and State requirements for providing and claiming reimbursement for OTP services.

Response #2:

OASAS will issue guidance to OTP providers reminding them of their obligations to comply with state and federal laws and rules for providing and claiming Medicaid reimbursement for OTP services including Utilization Review requirements (14 NYCRR 822.7) and Medicaid Compliance Program obligations (18 NYCRR Part 521). To the extent OTPs discover billing anomalies, they will be reminded to comply with the requirements of self-disclosure of overpayments to the OMIG.

Of note, for all of the 8 of 150 claims in the sample that the providers did not document that the associated beneficiary was diagnosed as being addicted to or dependent on an opioid drug in the clinical record or treatment plans, the 8 claims submitted by the providers documented the following diagnoses: F1120- Opioid Dependence, Uncomplicated or 30400- Opioid Type Dependence, Unspecified.

Recommendation #3:

Implement procedures to detect and prevent duplicate claims for OTP services.

Response #3:

OASAS will issue guidance in January 2020 to OTP providers reminding them of their obligations to comply with Utilization Review requirements (14 NYCRR 822.7) and Medicaid Compliance Program obligations (18 NYCRR Part 521). To the extent such reviews reveal duplicate claims, they will be reminded to comply with the requirements of self-disclosure of overpayments to the OMIG.

Additionally, the Department is investigating if system edits will be required to detect and prevent duplicate claims for OTP services.

[REDACTED]

From: CDC IMS State Coordination Task Force (SCTF) Operations <eocstfops@cdc.gov>
Sent: Monday, February 3, 2020 10:15 AM
To: CDC IMS State Coordination Task Force (SCTF) Operations; Greene, Danielle (HEALTH)
Subject: FW: CDC Returning Traveler Discussion
When: Monday, February 3, 2020 3:00 PM-4:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Bridgeline: 1(888)324-9603 Passcode: [REDACTED] OR Rm. TBD

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-----Original Appointment-----

From: CDC IMS State Coordination Task Force (SCTF) Operations <eocstfops@cdc.gov <mailto:eocstfops@cdc.gov> >
Sent: Monday, February 03, 2020 10:13 AM
To: CDC IMS State Coordination Task Force (SCTF) Operations; CDC IMS State Coordination Task Force (SCTF) Lead; Kosmos, Christine (CDC/DDPHSIS/CPR/DSLRL); Butler, Jay C. (CDC/DDID/OD); CDC IMS 2019 NCOV Response Chief of Staff; bferrer@ph.lacounty.gov <mailto:bferrer@ph.lacounty.gov> ; Stella Fogleman; Wiesman, John (CDC doh.wa.gov); Halvorson, Clark (CDC doh.wa.gov); sonia.angell@cdph.ca.gov <mailto:sonia.angell@cdph.ca.gov> ; Susan Fanelli; Arwady, Allison AA (CDC cityofchicago.org); Christopher Shields; Rawls, Winfred; Zucker, Howard A (HEALTH); Primeau, Michael J (HEALTH); Beth Maldin (bmaldin@health.nyc.gov <mailto:bmaldin@health.nyc.gov>); kathleen.toomey@dph.ga.gov <mailto:kathleen.toomey@dph.ga.gov> ; Minarcine, Scott; bruce.s.anderson@doh.hawaii.gov <mailto:bruce.s.anderson@doh.hawaii.gov> ; Hutton, Brad J (HEALTH); Dreslin, Sally R (HEALTH); Blog, Debra S (HEALTH); Kuhles, Daniel J (HEALTH); CDC IMS State Coordination Task Force (SCTF) Policy & Comm; Mermin, Jonathan (CDC/DDID/NCHHSTP/OD); Williams, Ian (CDC/DDID/NCEZID/DFWED); Eisenberg, Emily (CDC/DDID/NCIRD/ID); Cohn, Amanda (CDC/DDID/NCIRD/OD); Berger, Sherri (CDC/OCOO/OD); Daley, Walter (Randolph) (CDC/DDPHSIS/CPR/DSLRL); Pesik, Nicki (CDC/DDID/NCEZID/OD); Weinbaum, Cindy (CDC/DDID/NCIRD/ISD); Roohi, Shahrokh (CDC/DDID/NCEZID/DGMQ); Rotz, Lisa (CDC/DDID/NCEZID/DGMQ); Brown, Clive (CDC/DDID/NCEZID/DGMQ); CDC IMS Response Coordinator -2; Weir, Charles (OS/ASPR/IO)
Subject: CDC Returning Traveler Discussion
When: Monday, February 03, 2020 3:00 PM-4:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Bridgeline: 1(888)324-9603 Passcode: [REDACTED] OR Rm. TBD

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CDC Returning Traveler Discussion

CDC's 2019 Novel Coronavirus (2019-nCoV) response team will host a call from 3 p.m. to 4 p.m. EST on Monday, February 3, to discuss plans for returning travelers within the eleven funneling jurisdictions, status reports and concerns. Feel free to include your state epidemiologist, preparedness director, state/city emergency management official, and other core team members.

Bridgeline: 1(888)324-9603

Participant: [REDACTED]

State Coordination Task Force (SCTF)

Division of State and Local Readiness (DSLRL)

Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC <<http://www.cdc.gov/>>)
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027

From: [Anderson, Jade \(CDC/DDPHSIS/CPR/DSLRL\)](#)
To: [bferrer@ph.lacounty.gov](#); [Stella Fogleman](#); [Wiesman, John \(CDC doh.wa.gov\)](#); [Halvorson, Clark \(CDC doh.wa.gov\)](#); [sonia.angell@cdph.ca.gov](#); [Susan Fanelli](#); [Arwady, Allison AA \(CDC cityofchicago.org\)](#); [Christopher Shields](#); [Rawls, Winfred](#); [Zucker, Howard A \(HEALTH\)](#); [Primeau, Michael J \(HEALTH\)](#); [Beth; kathleen.toomey@dph.ga.gov](#); [Minarcine, Scott](#); [bruce.s.anderson@doh.hawaii.gov](#); [Hutton, Brad J \(HEALTH\)](#); [Dreslin, Sally R \(HEALTH\)](#); [Bloq, Debra S \(HEALTH\)](#); [Kuhles, Daniel J \(HEALTH\)](#); [bryron.backenson@health.ny.gov](#)
Cc: [Butler, Jay C. \(CDC/DDID/OD\)](#); [Kosmos, Christine \(CDC/DDPHSIS/CPR/DSLRL\)](#)
Subject: CDC Question One-Pager
Date: Monday, February 3, 2020 9:52:52 AM
Attachments: [CDC 1 Pager fin feb 2 2020.docx](#)

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Good Morning,

Attached, you will find a one-pager you might find helpful to assist with talking points and messaging to your jurisdiction. Thank you!

Respectfully,

Jade Anderson, MPA

Special Advisor/Public Health Analyst
Division of State and Local Readiness (DSLRL)
Center for Preparedness and Response (CPR)

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1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027
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e-mail: Jade.Anderson@cdc.hhs.gov



PART I: Answers to Questions RE: Quarantined Individuals in Hotels

How are quarantined individuals separated from the rest of guests in the hotel?

When hotels are being used, blocks of rooms are booked that are situated close together, and away from other hotel guests.

Who provides security?

Generally, state and local partners have provided security. As explained in bullets below, most times quarantine or isolation actions are effectuated by State and local jurisdictions, not the federal Government. However, if hotels will be used to lodge persons under federal quarantine orders, CDC would most likely use federal law enforcement (*i.e.* U.S. Marshals Service) to provide such services.

What is their freedom of movement? E.g., confined to room? Confined to hotel premises?

Quarantined individuals will be confined to their rooms, and will not be provided access to the rest of the hotel.

How are quarantined individuals fed?

Food will be ordered and delivered directly to their rooms. Quarantined individuals will not have access to hotel restaurants.

Part II: Background Regarding Federal vs. State and Local Quarantine

- Historically, federal quarantine authority over persons has rarely been invoked and, when it has been, only in regard to individual cases of exposed or infected travelers.
- Rather than ordering a large-scale quarantine, the federal government has recommended restrictions on public activities as a means of preventing communicable disease spread, or has worked with state and local health officials and agencies to utilize state and local authorities to limit movement of patients.
- Since 2007, the CDC has, on average, issued one isolation order per year, mostly for travelers who are known or suspected of being infected with drug resistant tuberculosis. In these cases, the CDC has used its federal authority to transport the infected traveler to a local hospital, take steps to confirm the diagnosis, and offer voluntary medical treatment.
- Typically, the CDC rescinds its federal isolation after the first seventy-two hours of detention once a local public health authority has agreed to accept custody of the patient.
- The CDC has also used its federal authority to facilitate the movement of infected patients into the United States or across state lines as part of a transfer between hospitals or for purposes of allowing such individuals to seek medical treatment in the United States.

- CDC's quarantine regulations provide the CDC Director with authority to detain and isolate arriving individuals whenever the Director has reason to believe that such an individual has been exposed to certain communicable diseases.
- CDC regulations also authorize the Director to require that an individual undergo a medical examination as part of a Federal order for quarantine, isolation, or conditional release for a quarantinable communicable disease.
- CDC regulations also describe the requirements relating to the issuance of a written federal order for quarantine, isolation, or conditional release, including the specific language and description of the processes and rights that must be included in such orders. Such orders must be served within 72 hours after apprehending the individual for quarantine or isolation.
- In practice, CDC typically transfers subjects of apprehension to state or local authorities before issuing a federal order.
- CDC works closely with state and local health and emergency management. Activities are coordinated across all agencies, and CDC provides necessary health-related information for isolation, movement, monitoring, etc. State and locals, depending on the jurisdiction, serve as lead on-the-ground for logistics.
- For this outbreak, CDC has and will continue to issue guidance to state and local departments. Guidance documents, such as the PDF attached, have been distributed to the public health community. Additional guidance is forthcoming. If a passenger requires housing for the remaining time period (since last in the Hubei), CDC will be onsite at the airport and available by telephone from HQ, to assist.

[REDACTED]

From: CDC IMS State Coordination Task Force (SCTF) Operations <eocsctfops@cdc.gov>
Sent: Thursday, January 16, 2020 11:24 PM
To: CDC IMS State Coordination Task Force (SCTF) Operations; Silvia, Jacki S (HEALTH); Brazzell, Sarah E (HEALTH); Ortega, Alexandria P (HEALTH)
Subject: All State Update Call - 2019 nCoV
When: Monday, February 03, 2020 2:00 PM-2:45 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Bridgeline: 1(800)857-6697 Participant Passcode: [REDACTED]

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CDC's 2019 Novel Coronavirus (2019-nCoV) response team will continue a series of national calls from 2 p.m. to 3 p.m. EST on Monday, January 27, to provide state and local partners with the latest information on the novel coronavirus outbreak and U.S. preparedness efforts.

Invited participants include state, local, and territorial preparedness directors, state epidemiologists, state health officials, public health laboratory directors, and nongovernmental partners. Participant information can be found below.

Participant Information

Bridgeline: 1(800)-857-6697

Participant Passcode: [REDACTED]

For your convenience, call series dates are provided below.

- * Monday, February 3
- * Monday, February 10
- * Monday, February 24
- * Monday, March 2

CDC State Coordination Task Force (SCTF) - Operations

eocsctfops@cdc.gov <mailto:eocsctfops@cdc.gov>

<https://www.cdc.gov/coronavirus/novel-coronavirus-2019.html> <<https://www.cdc.gov/coronavirus/novel-coronavirus-2019.html>>

From: [Anderson, Jade \(CDC/DDPHSIS/CPR/DSLRL\)](#)
To: [bferrer@ph.lacounty.gov](#); [Stella Fogleman](#); [Wiesman, John \(CDC doh.wa.gov\)](#); [Halvorson, Clark \(CDC doh.wa.gov\)](#); [sonia.angell@cdph.ca.gov](#); [Susan Fanelli](#); [Arwady, Allison AA \(CDC cityofchicago.org\)](#); [Christopher Shields](#); [Rawls, Winfred](#); [Zucker, Howard A \(HEALTH\)](#); [Primeau, Michael J \(HEALTH\)](#); [Beth; kathleen.toomey@dph.ga.gov](#); [Minarcine, Scott](#); [bruce.s.anderson@doh.hawaii.gov](#); [Hutton, Brad J \(HEALTH\)](#); [Zucker, Howard A \(HEALTH\)](#); [Dreslin, Sally R \(HEALTH\)](#); [Hutton, Brad J \(HEALTH\)](#); [Blog, Debra S \(HEALTH\)](#); [Kuhles, Daniel J \(HEALTH\)](#); [bryron.backenson@health.ny.gov](#); [Zucker, Howard A \(HEALTH\)](#); [Hutton, Brad J \(HEALTH\)](#)
Cc: [CDC IMS State Coordination Task Force \(SCTF\) Policy & Comm](#)
Subject: CDC & FAA Interim Airline Guidance
Date: Monday, February 3, 2020 6:26:15 AM
Attachments: [CDC FAA airline guidance.pdf](#)

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Good Morning,

Attached, you will find combined Interim Health Guidance from the Federal Aviation Administration and the Centers for Disease Control and Prevention for Air Carriers and Crews. Please let us know if you have any questions.

Respectfully,

Jade Anderson, MPA

Special Advisor/Public Health Analyst
Division of State and Local Readiness (DSLRL)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention ([CDC](#))
1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027
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**2019 Novel Coronavirus:
Interim Health Guidance from the Federal Aviation Administration and
the Centers for Disease Control and Prevention for
Air Carriers and Crews**

February 2, 2020

Purpose

The United States has confirmed cases of individuals who have a contagious, respiratory illness caused by a novel (new) coronavirus (“2019-nCoV”) first detected in Wuhan City, Hubei Province, China. This virus has rapidly spread across China and Chinese health officials have reported thousands of infections with 2019-nCoV in China, with evidence of the virus spreading from person-to-person in many parts of that country.

The Director General of the World Health Organization has declared that the outbreak of 2019-nCoV constitutes a Public Health Emergency of International Concern. The Secretary of the U.S. Department of Health and Human Services has declared that 2019-nCoV constitutes a public health emergency. The Centers for Disease Control (CDC) is closely watching for spread in the United States and is actively monitoring hundreds of individuals with contacts related to Wuhan City.

The CDC and FAA are providing the following health guidance for: U.S.-based flight and cabin crewmembers while in China; U.S.- and third country-based flight and cabin crewmembers upon arriving to the United States within 14 days of travel to, from, or within China; China-based flight and cabin crewmembers while in the U.S.; U.S. air carriers housing flight and cabin crews while in China; and U.S. air carriers supervising self-monitoring of flight and cabin crews who have had layovers in China.

Guidance for U.S.-based flight and cabin crews while in China:

- Travel as a group in private transport provided by the air carrier when traveling between the airport and hotel.
 - Minimize contact with ground personnel and time in public areas while moving between the aircraft and the private transport.
 - Do not use public transportation, including when traveling between the airport and hotel.
- Minimize going out into the general population, and use social distancing (maintain a distance of approximately 6 feet, if possible) whenever out in public. Avoid crowds, stores, sporting or mass entertainment events, and other situations likely to attract large numbers of people.

- Wash your hands often with soap and water for at least 20 seconds or use at least a 60% alcohol-based hand sanitizer.
- Avoid touching your face.
- Self-monitor your health condition, following the guidance provided by your employer's occupational health program.
 - Take your temperature with a thermometer twice a day and watch for cough or difficulty breathing. Fever means feeling feverish or having a measured temperature of 100.4°F (38°C) or higher.
 - Immediately report any fever, cough, or difficulty breathing to your employer's occupational health program.
 - Seek occupational health clearance before working your next flight segment.
 - Your employer's occupational health program also is recommended to check in with you periodically to make sure you are well.
- Your employer's occupational health program may choose to exceed these recommendations based on their own policy.

Guidance for U.S. and Third Country-based flight and cabin crews upon arriving to the U.S. within 14 days of travel to, from, or within China:

- U.S. crewmembers may commute to their residence after the flight segment.
- Crewmembers may continue to work subsequent flight segments, as long as they remain asymptomatic.
- For 14 days, self-monitor your health condition, following the guidance provided by your employer's occupational health program.
 - Take your temperature with a thermometer twice a day and watch for cough or difficulty breathing. Fever means feeling feverish or having a measured temperature of 100.4°F (38°C) or higher.
 - Immediately report a fever, cough, or difficulty breathing to your air carrier employer's occupational health program.
 - Seek occupational health clearance before working your next flight segment.
 - Your air carrier employer is recommended to notify the local health department and the CDC of the crewmember's symptoms.
 - Call ahead to the local health department or your doctor for medical advice before seeking care.
 - Tell them your symptoms and that you were in China.

- Tell them you work for an airline. Avoid touching your face, wash your hands frequently, and use hand sanitizers.
- Your employer's occupational health program may choose to exceed these recommendations based on their own policy.

Guidance for China-based flight and cabin crews upon arriving to the U.S. within 14 days of travel to, from, or within China:

- Travel as a group in private transport provided by the air carrier when traveling between the airport and hotel.
 - Minimize contact with ground personnel and time in public areas while moving between the aircraft and the private transport.
 - Do not use public transportation, including when traveling between the airport and hotel.
- Stay in your hotel to the maximum extent feasible.
- Minimize going out into the general population and use social distancing (maintain a distance of approximately 6 feet, if possible) whenever out in public. Avoid crowds, stores, sporting or mass entertainment events, and other situations likely to attract large numbers of people.
- Wash your hands often with soap and water for at least 20 seconds or use at least a 60% alcohol-based hand sanitizer.
- Avoid touching your face.
- Self-monitor your health condition, following the guidance provided by your employer's occupational health program.
 - Take your temperature with a thermometer twice a day and watch for cough or difficulty breathing. Fever means feeling feverish or having a measured temperature of 100.4°F (38°C) or higher.
 - Immediately report any fever, cough, or difficulty breathing to your employer's occupational health program.
 - Seek occupational health clearance before working your next flight segment.
 - Your employer's occupational health program also is recommended to check in with you periodically to make sure you are well.
- Your employer's occupational health program may choose to exceed these recommendations based on their own policy.

Guidance for U.S. air carriers housing flight and cabin crews while in China:

- Arrange to move flight crews as a group between the airport and the hotel aboard private ground transport that has been sanitized in advance. Advise your crews to avoid public transport unless it is an emergency.
- Arrange to house flight crews in hotels that are in close proximity to the airport. Ensure that the hotel rooms are sanitized in advance of the crews' arrival.
- Provide crew with at least a 60% alcohol-based hand sanitizer.
- Encourage crews to minimize going out into the general population, and to use social distancing (maintain a distance of approximately 6 feet, if possible) whenever out in public. Encourage crews to avoid crowds, stores, sporting or mass entertainment events, and other situations likely to attract large numbers of people.
- The U.S. air carrier occupational health program may choose to exceed these recommendations based on their own policy.

Guidance for U.S. air carriers supervising self-monitoring of flight and cabin crews who have had layovers in China:

- Crewmembers may commute to their residence.
- Crewmembers may continue to work subsequent flight segments, as long as they remain asymptomatic.
- Supervise crew self-monitoring of their health condition through the carrier's occupational health program.
 - Direct crewmembers to take their temperature twice daily.
 - Remind crewmembers to immediately report a fever, cough, or any difficulty breathing.
 - Check in with crewmembers periodically to make sure they continue to self-monitor and are not symptomatic.
 - Crewmembers who are symptomatic with fever, cough or difficulty breathing should not work subsequent flight segments until they have been cleared by occupational health and public health officials.
 - Immediately report—both to the local health department where the crewmember is located at the time (if the crewmember is located in the United States) and to CDC—any crewmember who has traveled to China within the last 14 days and has a fever, cough, difficulty breathing, or other flu-like symptoms that prevent the crewmember from carrying out assigned duties.

- For this purpose, contact CDC by calling the Emergency Operations Center at 770-488-7100. CDC can also assist in contacting the state and local health department, if needed.
- Provide information to crewmembers regarding medical facilities in the vicinity of cities in which crewmembers remain overnight.
- Develop a plan in the event a crewmember becomes symptomatic while in the crewmember's domicile or personal residence. Advise crewmembers to report any fever, cough, or difficulty breathing to their local health department where they are located when they become symptomatic, in addition to the employer's occupational health program.
- The U.S. air carrier occupational health program may choose to exceed these recommendations based on their own policy.

From: [CDC IMS State Coordination Task Force \(SCTF\) Policy & Comm](#)
To: [bferrer@ph.lacounty.gov](#); [Stella Fogleman](#); [Wiesman, John \(CDC doh.wa.gov\)](#); [Halvorson, Clark \(CDC doh.wa.gov\)](#); [sonia.angell@cdph.ca.gov](#); [Susan Fanelli](#); [Arwady, Allison AA \(CDC cityofchicago.org\)](#); [Christopher Shields](#); [Rawls, Winfred](#); [Zucker, Howard A \(HEALTH\)](#); [Primeau, Michael J \(HEALTH\)](#); [Beth](#); [kathleen.toomey@dph.ga.gov](#); [Minarcine, Scott](#); [bruce.s.anderson@doh.hawaii.gov](#); [Hutton, Brad J \(HEALTH\)](#)
Cc: [CDC IMS State Coordination Task Force \(SCTF\) Operations](#); [CDC IMS State Coordination Task Force \(SCTF\) Policy & Comm](#)
Subject: FW: Table displaying risk categories within the CDC Interim Monitoring and Movement Guidance
Date: Monday, February 3, 2020 5:20:51 AM
Attachments: [MandM table PDF 2 2.pdf](#)
[CDC 2019-nCoV Daily Key Points 1 31 2020 corrected.pdf](#)

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Good Morning,

In addition, to the movement and monitoring table Chris shared last night, I am sending out amended key points that were shared from our preparedness@cdc.gov functional mailbox. Thank you!

State Coordination Task Force (SCTF)

Division of State and Local Readiness (DSLRL)
Center for Preparedness and Response (CPR)

Centers for Disease Control and Prevention (CDC)

1600 Clifton Road, NE, MS H21-5, Atlanta, GA 30349-4027



From: Kosmos, Christine (CDC/DDPHSIS/CPR/DSLRL) <htv4@cdc.gov>

Sent: Sunday, February 2, 2020 11:32 PM

To: [bferrer@ph.lacounty.gov](#); [Stella Fogleman](#) <[sfogleman@ph.lacounty.gov](#)>; [Wiesman, John \(CDC doh.wa.gov\)](#) <[jmwiesman@doh.wa.gov](#)>; [Halvorson, Clark \(CDC doh.wa.gov\)](#) <[Clark.Halvorson@DOH.WA.GOV](#)>; [sonia.angell@cdph.ca.gov](#); [Susan Fanelli](#) <[susan.fanelli@cdph.ca.gov](#)>; [Arwady, Allison AA \(CDC cityofchicago.org\)](#) <[allison.arwady@cityofchicago.org](#)>; [Christopher Shields](#) <[christopher.shields@cityofchicago.org](#)>; [Rawls, Winfred](#) <[winfred.rawls@illinois.gov](#)>; [Zucker, Howard \(CDC health.ny.gov\)](#) <[howard.zucker@health.ny.gov](#)>; [Mike Primeau](#) ([mjp06@health.state.ny.us](#)) <[mjp06@health.state.ny.us](#)>; [Beth Maldin](#) ([bmaldin@health.nyc.gov](#)) <[bmaldin@health.nyc.gov](#)>; [kathleen.toomey@dph.ga.gov](#); [Minarcine, Scott](#) <[Scott.Minarcine@dph.ga.gov](#)>; [bruce.s.anderson@doh.hawaii.gov](#)

Cc: [CDC IMS State Coordination Task Force \(SCTF\) Lead](#) <[eocsctflead@cdc.gov](#)>; [CDC IMS State Coordination Task Force \(SCTF\) Operations](#) <[eocsctfops@cdc.gov](#)>; [CDC IMS State Coordination Task Force \(SCTF\) Policy & Comm](#) <[eocsctfpolcomm@cdc.gov](#)>; [Butler, Jay C. \(CDC/DDID/OD\)](#) <[jcb3@cdc.gov](#)>; [Mermin, Jonathan \(CDC/DDID/NCHHSTP/OD\)](#) <[jhm7@cdc.gov](#)>; [Williams, Ian \(CDC/DDID/NCEZID/DFWED\)](#) <[iaw3@cdc.gov](#)>; [Eisenberg, Emily \(CDC/DDID/NCIRD/ID\)](#) <[idq5@cdc.gov](#)>; [Cohn, Amanda \(CDC/DDID/NCIRD/OD\)](#) <[anc0@cdc.gov](#)>; [Berger, Sherri](#)

(CDC/OCOO/OD) <sob8@cdc.gov>

Subject: Table displaying risk categories within the CDC Interim Monitoring and Movement Guidance

All,

Apologies for the late night email. Attached is a table that will be included in the CDC interim guidance on monitoring and movement. We expect the full guidance will be released as soon as tomorrow. In the meantime, the attached table should provide sufficient information regarding the risk categories and recommended actions. We will discuss the details tomorrow on our call. Pls feel free to forward to anyone I have inadvertently left off this email.

Chris Kosmos

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CDC Daily Key Points — CORRECTED
2019 Novel Coronavirus (2019-nCoV)

January 31, 2020

MAIN KEY POINTS

- There is an expanding outbreak **centered** in China of respiratory illness caused by a novel (new) coronavirus abbreviated “2019-nCoV.”
- This virus is spreading from person-to-person in China. A growing number of counties are reporting cases in travelers from China.
- Some limited person-to-person spread has been reported in countries outside of China. **Spread from an infected person who did not have symptoms to another person has been reported as well (i.e., asymptomatic spread).**
- On January 31, Health and Human Services Secretary Alex M. Azar II **declared a public health emergency for the United States to aid the nation’s healthcare community in responding to 2019 novel coronavirus.**
- **Also on January 31, the President of the United States signed a presidential “Proclamation on Suspension of Entry as Immigrants and Nonimmigrants of Persons who Pose a Risk of Transmitting 2019 Novel Coronavirus.”**
- **Measures were announced at a press briefing by members of the President’s Coronavirus Task Force.**
- This announcement follows the decision by the International Health Regulations Emergency Committee of the World Health Organization (WHO) to declare the outbreak a “public health emergency of international concern” (PHEIC).
- The situation is rapidly changing and we are monitoring it closely. Guidance will be updated as needed.
- Outbreaks like this – when a new virus is emerging to infect people – are always concerning. Some people might be worried about this virus and how it may impact Americans.
 - While this situation poses a very serious public health threat, CDC believes the immediate risk to the U.S. public continues to be low at this time.
 - Risk also depends on exposure. People exposed to ill persons are at greater risk of infection. (For example, healthcare workers and family members caring for people with 2019-CoV.)
 - However, the situation is evolving, and risk will depend on how well the virus spreads, how widely it spreads, and how sick it makes people.
- CDC has activated its Emergency Operations Center and is implementing an aggressive public health response in collaboration with federal, state and local partners.
- The goal of the ongoing U.S. public health **response is to prevent sustained spread of 2019-nCoV in this country. Strong measures now may blunt the impact of the virus on the United States.**
- The coming days and weeks are likely to bring more confirmed cases of 2019-nCoV in the United States and globally.

SITUATION UPDATE

- On January 31, 2020, CDC issued federal quarantine orders to all 195 persons repatriated to the U.S. from Wuhan, China this week under statutory authority of the Health and Human Services Secretary. The quarantine will

last 14 days from when the plane left Wuhan, China. This action is a precautionary and preventive step to maximize the containment of the virus in the interest of the health of the American public.

- A New England Journal of Medicine [letter to the Editor](#) on January 30, 2020 reported on a case of 2019-nCoV infection acquired outside of Asia in which transmission appears to have occurred during the incubation period in the index patient.
- To date, 25 international locations (in addition to the U.S.) have reported confirmed cases of 2019-nCoV infection, including most recently Italy, Russia, Sweden and the United Kingdom.
- As of January 31, 2020, 7 infections with 2019-nCoV have been reported in the U.S. in four states – Arizona, California, Illinois, and Washington.
- The 6th infection with nCoV was detected in IL in a contact of the first 2019-nCoV patient and represents the first instance of person-to-person spread in the United States with this virus. The second IL patient reportedly had prolonged and close contact with the first patient.
- CDC is uploading the full genetic sequence of viruses from all U.S. patients into GenBank as they become available.
- CDC is working with state and local health departments on investigations to trace contacts of the U.S. 2019-nCoV patients to detect person-to-person spread.
- CDC will continue to lean forward on public health response efforts to protect Americans. We are working closely with state and local health departments and have teams on standby to deploy if needed. Our public health goal continues to be to protect the health of Americans by preventing community spread with this virus.
- CDC will work through WHO China country office to support Chinese public health counterparts and help improve understanding of this new disease, including learning more about transmissibility and severity. One Beijing-based CDC expert is currently working with WHO in China and additional CDC headquarters experts are being identified and prepared for deployment.

WHAT YOU CAN DO

- While the immediate risk of this new virus to the American public is believed to be low at this time, everyone can do their part to help us respond to this emerging public health threat:
 - It's currently flu and respiratory disease season and CDC recommends getting a flu vaccine, taking everyday preventive actions to help stop the spread of germs, and taking flu antivirals if prescribed.
 - If you are a healthcare provider, be on the look-out for people with who recently traveled from China and fever and respiratory symptoms.
 - If you are a healthcare provider caring for a 2019-nCoV patient, please take care of yourself and follow recommended infection control procedures.
 - For people who may have 2019-nCoV infection, please follow CDC guidance on how to reduce the risk of spreading your illness to others. This guidance is on the CDC website.

2019 Novel Coronavirus (2019-nCoV) Key Points continued

- For people who have had close contact with someone infected with 2019-nCoV who develop symptoms, contact your healthcare provider, and tell them about your symptoms and your exposure to a 2019-nCoV patient.

TRAVEL

- On January 31, 2020, the White House 2019 Novel Coronavirus Task Force held a press conference to announce the implementation of new travel policies.

For more information please visit the 2019 Novel Coronavirus Outbreak Page at:
<https://www.cdc.gov/coronavirus/2019-ncov/index.html>

Proposed Interim Movement and Monitoring Guidance for Asymptomatic Persons with Exposure to nCoV Infection- 02/02/2020

Note: Guidance for healthcare workers is not included in this table, will be included in separate document focused on healthcare workers

Asymptomatic Persons with Exposure Risk for nCoV				
Risk Category	Exposure Risk	Movement and Public Activity	Evaluation	Travel
High	➤ Contact with confirmed 2019-nCoV cases: • Household and intimate contacts ➤ Travelers from Hubei Province (in the last 14 days)	Remain under quarantine authority; no public activities	Daily active monitoring	Controlled
Medium	➤ Unprotected close contact (6 ft) with confirmed 2019-nCoV cases, other than high risk category ➤ Travelers from mainland China (in the last 14 days)	Remain at home. Avoid congregate settings, limit public activities and practice social distancing.	Active monitoring ¹ or self-monitoring with supervision	Recommend to not travel
Low	➤ Contact with confirmed 2019-nCoV case other than medium or high risk category	No restriction	Self-observation ²	No restriction
No known risk	➤ Interactions that do not meet the close contact definition (e.g., walking by or sitting more than 6 ft away from)	No restriction	None	No restriction

¹Frequency at discretion of state health department

²Does not include twice-daily temperature checks, language is to watch health for 14 days

From: [Butler, Jay C. \(CDC/DDID/OD\)](#)
To: [Wiesman, John \(CDC doh.wa.gov\)](#); [sonia.angell@cdph.ca.gov](#); [Zucker, Howard A \(HEALTH\)](#); [bruce.s.anderson@doh.hawaii.gov](#); [kathleen.toomey@dph.ga.gov](#); [Ngozi.Ezike@illinois.gov](#); [Christopher.Shields@cityofchicago.org](#); [sfoqleman@ph.lacounty.gov](#); [bmaldin@health.nyc.gov](#); [Angell, Sonia Y@CDPH](#)
Cc: [Mermin, Jonathan \(CDC/DDID/NCHHSTP/OD\)](#); [Kosmos, Christine \(CDC/DDPHSIS/CPR/DSLRL\)](#); [Eiring, Hilary \(CDC/DDID/OD\)](#)
Subject: interim Guidance on Housing of Persons in Q
Date: Sunday, February 2, 2020 11:51:01 AM
Attachments: [2019nCoV_InterimHousingGuidance_CDC_Feb12020.pdf](#)

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Jumping the system a bit to get these out to you ASAP, but this has completed CDC clearance.

Forthcoming:

1. Specific recommendations for home Q options (Hubei group)
2. Movement and monitoring guidance for travelers from rest of China



**Interim Recommendations regarding Shelter Characteristics for the 2019 Novel
Coronavirus Outbreak United States Government Repatriation Operation
1 February 2020**

Background:

In the setting of the expanding outbreak associated with a novel coronavirus from Wuhan, the United States Government has arranged for evacuation of US personnel in affected areas. Because these individuals will be evacuating from an outbreak zone, health screening and exposure risk assessments will be required to determine presence of illness or history of high-risk exposures upon entry to the US. Upon entry into the United States, these individuals will be placed under a quarantine order for 14 days after their last potential exposure to allow for illness detection and health monitoring. Individuals within the group will have different antecedent exposure risks. They should not be housed together in congregate settings, where an individual who becomes symptomatic could expose the rest of the evacuees.

Shelter requirements:

- 1) Separate quarters with separate bathroom facilities for each individual or family group are preferred.
 - a. Cleaning supplies, e.g. household cleaning wipes, must be provided in any shared bathroom.
 - b. If an individual sharing a bathroom becomes symptomatic, all others sharing the bathroom should be considered PUI contacts until the symptomatic person is appropriately evaluated and cleared.
- 2) No close congregation for social or dining activities. Food should be delivered to the individual quarters.
- 3) Overhead announcements and group SMS should be used instead of physical gatherings to share information.
- 4) Quarters should have a supply of face masks for individuals to put on if they become symptomatic.
- 5) Other support services (e.g. laundry, prescription medication refills, telephone/wifi/communication capability) will need to be provided.
- 6) Garbage should be bagged and left outside by the door of each of the quarters for routine pick up. Special handling is not required.
- 7) Appropriate infection control capabilities to manage initial clinical assessment of individuals who become ill should include a designated room(s) with a door that can be closed. The room(s) should be separate from residential facilities. Symptomatic individuals should be promptly evaluated and, if appropriate, await transfer to a medical facility in the room keeping the door closed. The room should be supplied with disposable facemasks for the ill individual to wear throughout the evaluation and

transport process. Cleaning supplies e.g., hospital disinfectant spray or wipes, should be stocked in each evaluation room to clean and disinfect the room's surfaces after it's vacated by the ill individual. Current CDC healthcare guidance is here:

<https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html>

- 8) Each residential space, all common areas for staff members, and each clinical evaluation room must have supplies of alcohol-based hand rubs, as well as sinks with soap and water, and paper towels.
- 9) PPE supplies (disposable face shields, N95 disposable respirators, disposable gowns and gloves) should be maintained in each clinical assessment area to allow for response and assessment of individuals who become ill.
- 10) A system for temperature and symptom monitoring should provide assessment in-place for the individuals/family groups in their separate quarters.
- 11) Nearby medical facilities should have the capability to manage the assessment and treatment of ill persons (to include normal airborne infection isolation rooms)
- 12) The location should be secure against unauthorized access and be appropriate for enforcing quarantine, if enacted.



Michael Bell, MD
Deputy Director, Division of Healthcare Quality Promotion
Centers for Disease Control and Prevention

From: [Centers for Disease Control and Prevention](#)
To: [Dreslin, Sally R \(HEALTH\)](#)
Subject: CDC Health Alert Network (HAN) Health Update: Update and Interim Guidance on Outbreak of 2019 Novel Coronavirus (2019-nCoV)
Date: Saturday, February 1, 2020 1:12:43 PM

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CDC issued the following Health Alert Network (HAN) Health Update on February 1, 2020. You are receiving this information because you subscribe to COCA email updates. If a colleague forwarded this email to you, yet you would like to receive future updates directly from COCA, [click here](#).

If you have any questions about this or other clinical issues, please e-mail coca@cdc.gov

On behalf of the Clinician Outreach and Communication Activity (COCA)
Centers for Disease Control and Prevention (CDC)
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HAN - this is an official CDC Health Update



Distributed via the CDC Health Alert Network
February 1, 2020, 0900 ET (9:00 AM ET)
CDCHAN-00427

Update and Interim Guidance on Outbreak of 2019 Novel Coronavirus (2019-nCoV)

Summary

The Centers for Disease Control and Prevention (CDC) continues to closely monitor an outbreak of respiratory illness caused by a novel coronavirus (2019-nCoV) that was initially detected in Wuhan City, Hubei Province, China in December 2019.

This CDC Health Alert Network (HAN) Update provides a situational update and interim

guidance to state and local health departments that supersedes guidance in CDC's HAN 426 distributed on January 17, 2020. It also adds

- guidance for clinicians caring for patients with 2019-nCoV (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>),
- and for public health officials on the evaluation and testing of patients under investigation (PUIs) for 2019-nCoV (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>), and
- updated infection prevention and control guidance specific to 2019-nCoV (<https://www.cdc.gov/coronavirus/2019-nCoV/hcp/infection-control.html>).

Early in the outbreak, many of the patients with respiratory illness caused by 2019-nCoV in China had exposure to a large seafood and live animal market, suggesting animal-to-human transmission. More recently, cases have been confirmed with no exposure to animal markets, indicating that person-to-person spread of the virus has occurred. Chinese officials report that sustained person-to-person spread in the community is occurring in China.

The first US case-patient was identified on January 21, 2020, and had recently traveled from Wuhan, China. Since that time, six additional cases have been confirmed in the United States, four among persons who traveled from Wuhan, and one a close contact of a confirmed case. Globally, reported illnesses in people with 2019-nCoV have ranged from mild (no or few signs and symptoms), to severe, including death. These findings are consistent with other coronaviruses, including Severe Acute Respiratory Syndrome (SARS) (<https://www.cdc.gov/sars/>) and Middle East Respiratory Syndrome (MERS) (<https://www.cdc.gov/coronavirus/mers/index.html>). Additional information about 2019-nCoV is needed to better understand transmission, disease severity, and risk to the general population. The goal of the ongoing US public health response is to identify and contain this outbreak and prevent sustained spread of 2019-nCoV in the United States.

Recommendations for Screening of Patients for 2019-nCoV in Healthcare Facilities

Recommendations for screening of patients for possible 2019-nCoV infection are based on (1) current knowledge of the characteristics of clinical illness observed in early cases, and (2) the geographic distribution of current cases. They reflect the current public health goal of rapidly containing and preventing transmission of 2019-nCoV illness.

Patients presenting to healthcare facilities should be assessed for exposures associated with risk of 2019-nCoV infections (e.g., travel to China or close contact with a confirmed case) and for symptoms consistent with 2019-nCoV infection (<https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html>). The assessment is intended to allow healthcare providers to make decisions about appropriate infection control and management of patients. Note that the signs and symptoms of 2019-nCoV overlap with those associated with other viral respiratory tract infections. Given the time of year, common respiratory illnesses, including influenza, should also be considered in patients who are screened. (Figure 1)

Clinicians should ask:

- Does the person have fever or symptoms of lower respiratory infection, such as cough or shortness of breath?

AND

Has the patient traveled to mainland China within 14 days of symptom onset?

OR

- Has the patient had close contact¹ with a person confirmed with 2019-nCoV infection?

Figure 1.

Flowchart to Identify and Assess 2019 Novel Coronavirus



If a patient meets these criteria:

- To minimize the risk that other people will be exposed to individuals who may have 2019-nCoV, patients who report having these symptoms should be asked to wear a surgical mask as soon as they are identified and directed to a separate area, if possible, with at least 6 feet (2 meters) separation from other persons. Patients should be evaluated in a private room with the door closed, ideally an airborne

infection isolation room (AIIR), if available. Healthcare personnel entering the room should use standard precautions, contact precautions, airborne precautions, and use eye protection (e.g., goggles or a face shield). For more information about this, see CDC's *Interim Infection Prevention and Control Recommendations for Patients with Known or Patients Under Investigation for 2019 Novel Coronavirus (2019-nCoV) in a Healthcare Setting* (<https://www.cdc.gov/coronavirus/2019-nCoV/hcp/infection-control.html>).

Clinicians should immediately notify the healthcare facility's infection control personnel and local health department. The health department will determine if this patient needs to be considered a PUI for 2019-nCoV and be tested for infection.

Criteria to Guide Evaluation and Testing of Patients Under Investigation (PUI) for 2019-nCoV

Local health departments, in consultation with clinicians, should determine whether a patient is a PUI for 2019-nCoV. The CDC clinical criteria for 2019-nCoV PUIs have been developed based on available information about this novel virus, as well as what is known about SARS and MERS. These criteria are subject to change as additional information becomes available.

Clinical Features	AND	Epidemiologic Risk
Fever ² or signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)	AND	Any person, including health care workers, who has had close contact ¹ with a laboratory-confirmed ³ 2019-nCoV patient within 14 days of symptom onset
Fever ² and signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath)	AND	A history of travel from Hubei Province , China within 14 days of symptom onset
Fever ² and signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization ⁴	AND	A history of travel from mainland China within 14 days of symptom onset

These criteria are intended to serve as guidance for evaluation and testing. Patients should be evaluated and discussed with public health departments on a case-by-case basis for possible 2019-nCoV infection. Testing decisions might be further informed by the clinical presentation or exposure history (e.g., uncertain travel or exposure), and the presence of an alternative diagnosis that explains their clinical presentation.

Recommendations for Reporting, Testing, and Specimen Collection

Healthcare providers should **immediately** notify infection control personnel at their healthcare facility if a patient is classified a PUI for 2019-nCoV. State health departments that have identified a PUI should immediately contact CDC's Emergency Operations Center (EOC) at 770-488-7100 and complete a 2019-nCoV PUI case investigation form (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html#reporting-testing-specimen-collection>). CDC's EOC will assist local and state health departments with obtaining, storing, and shipping appropriate specimens to CDC, including afterhours or on weekends or holidays. Currently, diagnostic testing for 2019-nCoV can be done only at CDC. Testing for other respiratory pathogens should not delay specimen shipping to CDC.

For initial diagnostic testing for 2019-nCoV, CDC recommends collecting and testing upper respiratory (nasopharyngeal AND oropharyngeal swabs), and lower respiratory (sputum, if possible)) for those patients with productive coughs. Induction of sputum is not indicated. Specimens should be collected as soon as possible once a PUI is identified, regardless of the time of symptom onset. See *Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Patients Under Investigation (PUIs) for 2019 Novel Coronavirus (2019-nCoV)* (<https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html>).

Recommendations for Healthcare Providers

No vaccine or specific treatment for 2019-nCoV infection is available. At present, medical care for patients with 2019-nCoV is supportive.

Persons with confirmed or suspected 2019-nCoV infection who are hospitalized should be evaluated and cared for in a private room with the door closed, ideally an airborne infection isolation room, if available. For more information, see *Interim Infection Prevention and Control Recommendations for Patients with Known or Patients Under Investigation for 2019 Novel Coronavirus (2019-nCoV) in a Healthcare Setting* (<https://www.cdc.gov/coronavirus/2019-nCoV/hcp/infection-control.html>).

Home care and isolation may be an option, based on clinical and public health assessment, for some persons. Please see *Interim Guidance for Preventing the Spread of 2019 Novel Coronavirus (2019-nCoV) in Homes and Communities* (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-prevent-spread.html>).

Those isolated at home should be monitored by public health officials to the extent possible. Refer to *Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for 2019 Novel Coronavirus (2019-nCoV)* (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html>) for more information.

Notes

¹Close contact is defined as:

a) being within approximately 6 feet (2 meters), or within the room or care area, of a 2019-nCoV case for a prolonged period of time while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection); close contact can include caring for, living with, visiting, or sharing a health care waiting area or room with a 2019-nCoV case

- or -

b) having direct contact with infectious secretions of a 2019-nCoV case (e.g., being coughed on) while not wearing recommended personal protective equipment.

²Fever may be subjective or confirmed

See CDC's updated *Interim Infection Prevention and Control Recommendations for Patients with Known or Patients Under Investigation for 2019 Novel Coronavirus (2019-nCoV) in a Healthcare Setting* (<https://www.cdc.gov/coronavirus/2019-ncov/infection-control.html>).

Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with 2019-nCoV (e.g., coughing likely increases exposure risk as does exposure to a severely ill patient). Special consideration should be given to those exposed in health care settings.

³ Documentation of laboratory-confirmation of 2019-nCoV may not be possible for travelers or persons caring for patients in other countries.

⁴ Category also includes any member of a cluster of patients with severe acute lower respiratory illness (e.g., pneumonia, ARDS) of unknown etiology in which 2019-nCoV is being considered that requires hospitalization. Such persons should be evaluated in consultation with state and local health departments regardless of travel history.

For More Information

More information is available at the 2019 Novel Coronavirus website (<https://www.cdc.gov/coronavirus/2019-ncov/index.html>) or by calling 800-CDC-INFO | (800-232-4636) | TTY: (888) 232-6348

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

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##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##

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Centers for Disease Control and Prevention

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From: [HHS Region 2](#)
To: [Greene, Danielle \(HEALTH\)](#)
Subject: Weekly Updates: NCHS 2018 Drug Overdose Data, Coronavirus Update and More
Date: Friday, January 31, 2020 6:42:42 PM

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Dear Partner,

Please see our Weekly Updates below.

NCHS Data Brief 2018 Drug Overdose Data

Yesterday, CDC released an [NCHS Data Brief](#) that published final 2018 drug overdose data. As you all know, the Administration has committed unprecedented resources to combating the opioid crisis, and this data shows that after two years of President Trump's and Secretary Azar's leadership on this, there are signs of real progress. Fourteen states plus DC saw a statistically significant drop in their drug overdose death rates. While there is some good news, there is still work to be done. The data shows that while opioid overdoses overall are decreasing, synthetic opioids other than methadone (like fentanyl) are increasing. This is a disturbing trend that we are working to combat. In addition to some opioids still increasing, stimulants are also on the rise. In 2018, the age-adjusted rate of drug overdose deaths involving psychostimulants with abuse potential reached to a rate of 3.9 per 100,000 people. The Administration and the Department are committed to continuing building upon this success and bringing the overdose death rate lower for a healthier America.

View the NCHS Data Brief [here](#).
View the supporting data tables for the brief [here](#).

Coronavirus

The Department of Health and Human Services and the whole Administration are working diligently on the response to the outbreak of 2019-nCoV, the novel coronavirus that began in Hubei Province, China and has since spread to 22 countries across the globe. First, be assured that we are working hard to mitigate the impact on Americans. The U.S. has the best public health system in the world, and we are taking a whole of government approach to the response to this outbreak.

This past Wednesday, President Trump announced Secretary Azar as the chair of the [President's Coronavirus Task Force](#). The Secretary and our top public health officials are constantly monitoring the situation and formulating the necessary response posture from the U.S. As of right now, 6 people in the U.S. are confirmed to have 2019-nCoV (including one case of human to human transmission). More than 200 are under observation for potential contact with the disease. The virus is NOT currently spreading in the community in the U.S. There isn't an immediate risk to most people, and we continuously update the situation report. We want to keep the public as informed as possible and we learn new information on a regular basis, so we encourage you to visit the [CDC website on 2019-nCoV](#) for the most up to date information.

We encourage you to check out the Secretary's [recent press conference](#), [our FAQ on 2019-nCoV](#), the [transcript of CDC's telebriefing](#) announcing the first human to human transmission case in the U.S., and CDC's [media page](#) on nCoV.

CMS Healthy Adult Opportunity

Yesterday, the Centers for Medicare & Medicaid Services (CMS) announced the Healthy Adult Opportunity (HAO), an optional demonstration to support states with greater flexibility to improve the health of their Medicaid populations. The Healthy Adult Opportunity (HAO) emphasizes the principles of value-based care while granting states with extensive flexibility to administer and design their programs within a defined budget. This state opportunity will enhance the Medicaid program's integrity through its focus on accountability for results and quality improvement, making the Medicaid program stronger for states and beneficiaries.

For more information about Healthy Adult Opportunity, see the below resources:

- [Press Release](#)
 - [The State Medicaid Directors' letter](#)
 - [CMS Fact Sheet](#)
 - [Medicaid facts and figures](#)
-

Rural Community Action Guide

Today, the Trump Administration released a [new tool](#) to assist rural community leaders in building an effective local response to the crisis of addiction.

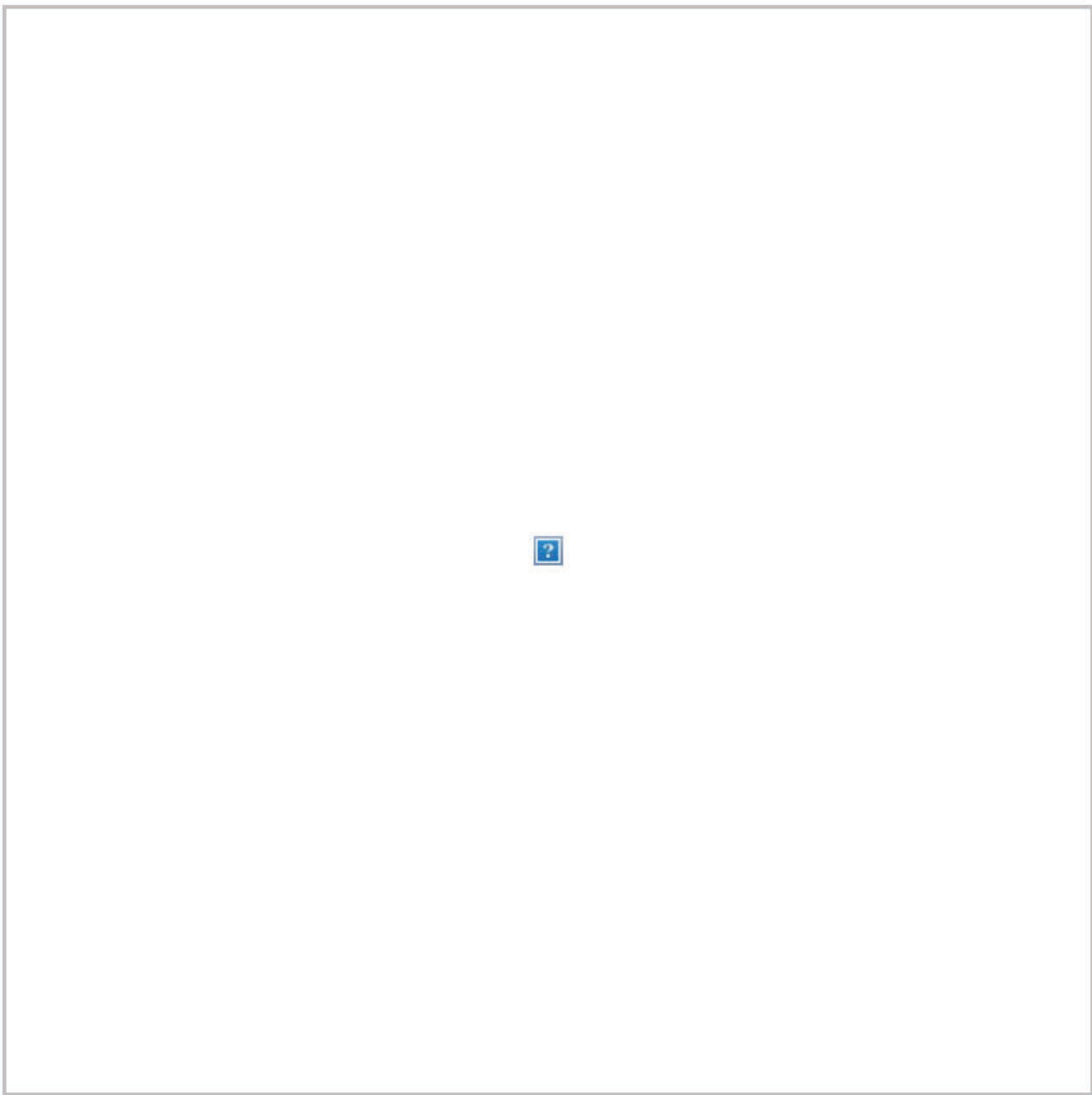
The [Rural Community Action Guide](#) includes background information, recommended action steps, and promising practices for a range of issues related to drug addiction in rural America.

The Action Guide complements both the [Community Assessment Tool](#), which gives county specific data about deaths and factors which may make a community more vulnerable to addiction, and the [Federal Rural Resources Guide](#), which includes comprehensive information about different federal funds for rural communities impacted by addiction.

The Action Guide is based on lessons learned from rural roundtable discussions held in over a dozen states, as well as the experiences of several rural stakeholder partners.

Have a fantastic weekend.

**Best regards,
HHS Region II**



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From: [Centers for Disease Control and Prevention](#)
To: [Dreslin, Sally R \(HEALTH\)](#)
Subject: Reminder - COCA Call Today: Outbreak of 2019 Novel Coronavirus (2019-nCoV)—Interim Guidance for Clinicians
Date: Friday, January 31, 2020 9:03:34 AM

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Clinician Outreach and Communication Activity (COCA) Call: Outbreak of 2019 Novel Coronavirus (2019-nCoV)—Interim Guidance for Clinicians

Overview

Date: Friday, January 31, 2020
Time: 2:00pm–3:00pm (ET)

During this COCA Call, clinicians will learn about the current epidemiology, infection control and prevention recommendations, specimen collection and testing, and clinical management for patients with 2019-nCoV infection.

Continuing Education will not be offered for this COCA Call.

Special Request: Due to the high demand we anticipate for this COCA Call, we kindly ask participants to access it in a group format, if at all possible, to allow for the maximum number of participants to attend.

Please note, there will be only a few introductory slides for this presentation. The subject matter covered during this webinar will not have an accompanying slide deck.

If you are unable to attend the live COCA Call, the closed captioned video will be available [here](#) a few days after the call.



A few minutes before the webinar begins, please click the link below to join:

<https://zoom.us/j/915683484>

Or iPhone one-tap:

US: +16468769923,,887744874# or
+16699006833,,915683484#

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US: +1 646 876 9923 or +1 669 900 6833

Webinar ID: 915 683 484

International numbers available:

<https://zoom.us/u/anixAVglV>

Presenters

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Centers for Disease Control and Prevention

The Emergency Risk Communication Branch in the Division of Emergency Operations, Center for Preparedness and Response is responsible for the management of all COCA products.

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- [Clinician Outreach and Communication Activity](#)—resources for healthcare providers
- [COCA RSS Feed](#)—subscribe to be notified of conference calls, updates, and CDC guidance for health providers
- [Crisis & Emergency Risk Communication Training](#)—training program that draws from lessons learned during public health emergencies, and incorporates best practices from the fields of risk and crisis communication
- [Health Alert Network](#)—CDC's primary method of sharing cleared information about urgent public health incidents with public information officers; federal, state, territorial, and local public health practitioners; clinicians; and public health laboratories

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